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Standards of Excellence
Hospice

Hospice

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INTRODUCTION TO CHAP HOSPICE STANDARDS

In keeping with its goal of elevating the quality of all community health care in the United States, the Community Health Accreditation Program, Inc. (CHAP) continually reviews and revises the "Standards of Excellence" to ensure currency with and relevance to the community health care industry. The 2008 service specific Hospice Standards are to be used as a blueprint to build and maintain a highly sophisticated hospice service.

- Establish standards of excellence for certified Hospice organizations
- Promote ease of application, interpretation and use of standards
- Emphasize the importance of the interests and rights of Hospice clients/families
- Strengthen the long-term viability of Hospice organizations
- Advance the recognition of the Hospice organization as an integral component of the national health care delivery system

The 2008 HOSPICE Standards of Excellence address the scope, complexity and challenges of providing comprehensive Hospice care in a variety of community based settings. The standards are intended to be used as a companion to the 2008 CORE standards and are intended to be non-duplicative and redundant of the CORE standards. When used in conjunction with the 2008 CORE Standards, compliance is ensured with:

- Hospice regulatory requirements/national industry standards
- Centers for Medicare and Medicaid Services (CMS) regulations (2008 Edition) for hospice organizations that elect to receive Medicare Certification through deeming authority from CHAP
- Regulatory requirements that address the health and safety of employees and clients

Additional Requirements for Medicare-Certified Hospice Services

CHAP has received authority from the Centers for Medicare and Medicaid Services (CMS) to deem certified hospice services to be in compliance with the Conditions of Participation (COP's). CHAP's CORE 2008 Standards and CHAP's Hospice 2008 Standards contain standards and criteria which include the intent of the 2008 Medicare COPs for hospice.

The hospice agency that elects to receive Medicare Certification through deeming authority from CHAP must comply with 42 CFR 418 Medicare Conditions of Participation for Hospice (2008 Edition). CHAP's CORE 2008 Standards contain 2008 Edition CFR references as notes in the Evidence Guidelines. CHAP's CORE 2008 Standards do not contain CFR identifiers in the body of the Standards, but instead include an Appendix 1 H which contains a full text of the Medicare Hospice regulations and a cross-walk to the CHAP Standards. CHAP's Hospice 2008 Standards contain CFR references in each related standard, criterion and element.

Hospice

Underlying Principles

Four key principles form the framework for the revised standards:

I. Structure and Function
II. Quality
III. Resources
IV. Long Term Viability

Standards
Self Study
Workbooks
Site Visit Reports

These four key "Underlying Principles" (UP) continue to drive each set of the CHAP Standards of Excellence. Sub-categories in standards in each section of the Core or Hospice Standards further define the content.

UP I. THE ORGANIZATION'S STRUCTURE AND FUNCTION CONSISTENTLY SUPPORTS ITS CONSUMER ORIENTED, MISSION

A. Statement of Mission
B. Organizational Structure And Functional Mechanisms
C. Intra-Organizational Relationships
D. Hospice Service Administrator
E. Hospice Specific Policies & Procedures

UP II. THE ORGANIZATION CONSISTENTLY PROVIDES HIGH QUALITY SERVICES AND PRODUCTS.

A. Public Disclosure, Client Rights, Ethics
B. Services Provided
C. 24-Hour Care
D. Access to Care/Services/Initial Assessment & Coordination
E. Plan of Care, Verbal Orders, Drugs, CLIA
F. Clinical Record
G. Service Provided in SNF/NF or ICF/MR
H. Inpatient Services
I. Short-Term Inpatient Care
J. Adequacy/Effectiveness of Care/Services
K. Health & Well Being of Employees/Clients

UP III. THE ORGANIZATION HAS ADEQUATE HUMAN, FINANCIAL AND PHYSICAL RESOURCES TO ACCOMPLISH ITS STATED MISSION

A. Human Resources Support Workload Demand
B. Staffing/Service Contracts
C. Management Information System

Hospice

UP IV. THE ORGANIZATION IS POSITIONED FOR LONG TERM VIABILITY.

A. Operational Planning
B. Annual Evaluation
C. Innovations

As you study and apply these standards to your own organization, give consideration to the following "*THEMES"* that flow through all sections of the CHAP Standards of Excellence and Self-Studies.

Composition of a Standard

Each standard statement may be comprised of four (4) parts:

1. Standard statement - A blueprint for success that recognizes excellence
2. Criterion - A statement that defines in detail the requirements of the standard
3. Element - A component part of each criterion that delineates requirements
4. Sub-element – Additional statements that provide more definition of selected elements

Examples
Standard:…… HI.1
Criterion…….. HI.1a
Element:……... 1)
Sub element……..(a) (not all standards have sub-elements)

Main Sources of Evidence

D = Documents
I = Interviews
O= Observations
S = Surveys

Substantiation of Findings

Clarification
Verification
Quantification

Evidence Guidelines

The Standards are formatted with relevant Evidence Guidelines on pages opposite the standards. The evidence guidelines are not standards or criteria. They are intended to provide guidelines and examples of evidence to the organization and to the CHAP site visitor which may be used to determine organizational compliance with the standards. The letter preceding each evidence guideline identifies one of four sources of information to be used by the site visitor in the accreditation process: D, I, O, S.

Hospice

The Site Visit Report

The Site Visit Report is a written legal document that states the level of compliance by the Hospice organization with both the CORE and Hospice Standards of Excellence. The composition of the report includes a brief organizational profile, statements of organizational strengths and challenges and the written citations.

Citations include:

Commendation:	A statement indicating that the organization has significantly exceeded the requirements of a specific standard or criterion.
Required Action:	A statement indicating partial or total non-compliance with a CHAP standard or criterion. Organizations are required to make changes to comply with CHAP standard or criterion.
Recommendation:	A statement of advisement that identifies a potential problem related to a standard or criterion that may increase in scope and severity if not addressed. Organizations are not required to make changes but should give serious consideration to the recommendation.

Medicare Deficiencies for Hospice Organizations:

Tag Items:

Identifiers used by CMS that indicate non-compliance with one or more Medicare Conditions Of Participation or Standards are defined as Tag Items.

Tag item designations are used in the CHAP Site Visit Report and on all required CMS documents.

Hospice

Abbreviations

Common abbreviations used throughout the Hospice Standards include:

CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments
d/b/a	Doing Business As
IDT/IDG	Interdisciplinary Team/Interdisciplinary Group
SNF	Skilled Nursing Facility

Hospice

HI.

THE HOSPICE SERVICE ORGANIZATION'S STRUCTURE AND FUNCTION CONSISTENTLY SUPPORT ITS CONSUMER ORIENTED MISSION

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HI.1

D: Current written mission statement is available and includes the dimensions of care detailed in the standard. (HI.1)

D: Policies and procedures reflect the hospice mission, including the seven elements in HI.1a.

I: The management and staff can verbalize the mission statement of the hospice. (HI.1a)

D: Management reports confirm that the services identified in the hospice mission statement are actually being delivered. (HI.1b)

I: Management and staff describe how services support the mission. (HI.1b)

I&O: All levels of staff verbalize and demonstrate an understanding of the hospice mission and indicate their support. (HI.1b)

I: Patients/families verbalize understanding of the Hospice mission. (HI.1c)

I: Management describes the process for making the Hospice mission statement available upon request. (HI.1d)

Hospice

HI.1 **Written mission statement affirms the concept of hospice and palliative care addressing the physical, social, psychological and spiritual dimensions of care as an integrated whole.**

HI.1a **The mission of the Hospice Service organization is reflected in the referral, admission, service policies and procedures, and demonstrate the ability to:**

1. **Establish a commitment to the concept of hospice care**
2. **Provide comprehensive, competent, quality care which optimizes comfort and dignity and is consistent with the patient and family needs and goals with the patient's needs and goals as priorities.**
3. **Deliver timely end-of-life care that is well-coordinated, family-centered and includes bereavement and counseling support**
4. **Case manage and design services that are consumer-oriented**
5. **Ensure continuity of care, consistent with the needs of the patient/family/caregiver, as it pertains to the terminal diagnosis, culture, environment and appropriate level of care**
6. **Acknowledge without discrimination the dignity, comfort and choices determined by the patient/family/caregiver including the election of the Medicare Benefit or alternative health care options**
7. **Design treatment protocols and interventions consistent with the mission of the organization**

HI.1b **The mission statement is supported through the interdisciplinary plan of care and the implementation and evaluation of hospice services.**

HI.1c **The patient/family care services implemented at each level of care consistently reflects the hospice mission.**

HI.1d **The hospice mission statement is made available upon request to patients, referral sources and other interested parties.**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HI.2

D: Organization complies with elements of HI.2a. If applicable, documents are available and current. (HI.2a)

D: Policies reflect the two elements in HI.2b.

D: Original or most current signed and dated written public disclosure statement is on file and signed by the CEO. Supplemental change documents are on file and signed by the CEO if applicable. (HI.2c)

D: Organization complies with HI.2d. If applicable, official documents are available and current. (HI.2d)

D & I: Managers and IDT/IDG members describe the process and documentation used to monitor services and validate care compliance at all locations. (HI.2d.4)

Hospice

HI.2 **The Hospice Organization has the structure and functional mechanisms necessary to support and accomplish its stated mission and clinical care.**

HI.2a **The Hospice Organization complies with local, state and federal laws and regulations.**

Evidence, as applicable, includes:

1. **Current state and/or local license**
2. **Medicare and Medicaid provider numbers**
3. **Business license**
4. **CLIA certification**
5. **Reports of other reviewing bodies**
6. **d/b/a state registration**
7. **Building Occupancy Permit (hospice-owned in-patient units)**
8. **Nursing Services Waiver of Requirement**
9. **Physical Therapy, Occupational Therapy, Speech Language Pathology and Dietary**
10. **Counseling Waiver of Requirement**
11. **Death reports to CMS per requirement**

HI.2b **The Hospice Organization applies the Medicare Conditions of Participation to all patients of hospice.**

1. **The Medicare Conditions of Participation for hospice programs apply to all patients of the hospice organization, both Medicare and non-Medicare.**

2. **The Medicare Conditions of Participation Continuation of Care Requirement (418.100(d)) and the 80-20 Inpatient Care Limitation (418.108 (d)) apply only to Medicare beneficiaries, not to non-Medicare patients.**

HI.2c **The organization is required to complete federal application forms pertaining to disclosure of ownership/organizational management for initial application to the Medicare Reimbursement Program and to report ongoing changes as required to appropriate state and federal agencies.**

HI.2d. **Hospices with multiple locations are required to meet the following requirements:**

1. **All hospice multiple locations are to be approved by Medicare and licensed in accordance with State licensure laws if applicable before providing Medicare reimbursed services.**
2. **All hospice multiple locations are to be part of the hospice and share administration, supervision and services with the hospice issued the certification number.**
3. **Lines of authority and professional/administrative control for hospice multiple locations are to be clearly delineated in the hospice's organizational structure and practice and are to be traceable to the location that issued the certification number.**
4. **Hospices are to monitor services provided at all of its locations to ensure that services are delivered in a safe and effective manner and that service is consistent with plans of care.**
5. **A determination that a multiple location does or does not meet the definition of a multiple location is an initial determination (498.3).**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
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S - SURVEY

HI.2 cont'd

I:	**Governing body members articulate responsibilities and describe the types of actions taken by the Board. (HI.2e)**
D:	**Official documentation or minutes reflect that the governing body designated a group to establish policies and procedures governing the day to day provision of hospice services. (HI.2e.3, HI.2e.5)**
D:	**Policies or other official documents identify member composition and responsibilities. (HI.2f, HI.2g)**
D:	**When applicable, documentation exists supporting requirements of HI.2e.4.**
D:	**IDT/IDG records reflect appropriate membership. (HI.2f, HI.2g)**
I:	**Team members verbalize their roles and contribution to team conferences. (HI.2f, HI.2g)**
O:	**IDT/IDG meetings have full participation of appropriate personnel. (HI.2f, HI.2g)**

Hospice

HI.2e. The governing body carries out responsibilities as designated in CI.2f and in addition carries out the following responsibilities for hospice:

1. **Assumes full legal authority and responsibility for:**
    a) **Determining, implementing and monitoring policies governing the hospice's total operations**
    b) **The management of hospice**
    c) **The provision of all hospice services**
    d) **Hospice fiscal operations**
    e) **Performance improvement**

2. **Appoints a qualified individual who is responsible for the day to day management of the hospice program.**
3. **Designates an interdisciplinary group or groups who provide the care and services offered by hospice to supervise the hospice care and services.**
4. **Ensures that one Interdisciplinary Group is designated in advance to establish policies and procedures governing the day to day provision of hospice care and services if a hospice has more than one interdisciplinary group.**
5. **Ensures that the interdisciplinary group maintains responsibility for directing, coordinating and supervising the care and services provided.**
6. **Ensures that substantially all Hospice core services are provided directly by hospice employees or are supplemented only during extraordinary and non-routine times via a process and circumstance that is consistent with CFR 42 418.64 requirements.**
7. **Ensures that all services provided are consistent with accepted standards of practice.**
8. **Ensures that care and services are provided in accordance with plans of care and that plans of care are based on assessments of patient/family needs.**
9. **Ensures that information is shared among disciplines (direct or contractual) in all hospice care/service settings.**
10. **Ensures that information is shared with non-hospice healthcare providers furnishing unrelated services.**
11. **Ensures that the hospice-wide performance improvement program:**
    a) **Is defined, implemented, maintained and evaluated annually.**
    b) **Addresses priorities and that all actions are evaluated for effectiveness.**
12. **Designates at least one individual to be responsible for the performance improvement operations.**

13. **Approves frequency and specific plan for performance improvement data collection.**

HI.2f The Hospice IDT/IDG membership includes employees who are qualified and competent to practice in the following professional roles:

1. **Doctor of Medicine or Osteopathy (may be by contract)**
2. **Registered Nurse**
3. **Social Worker**
4. **Pastoral or other counselor**

HI.2g Additional members of the IDT/IDG may include:

1. **Physical Therapist**
2. **Occupational Therapist**
3. **Speech Language Therapist/Audiologist**
4. **Dietitian**
5. **Pharmacist**
6. **Home Health Aide/Homemaker**
7. **Volunteer**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HI.2 cont'd

D: Policies or other official documents identify member composition and responsibilities of the IDT/IDG. (HI.2f, HI.2g, HI.2h)

I: Team members verbalize their roles and contribution to team conferences. (HI.2f, HI.2g, HI.2h)

O: IDT/IDG meetings have full participation of appropriate personnel. (HI.2g, HI.2h)

D: Clinical records and IDT/IDG minutes document fulfillment of staff responsibilities. (HI.2h)

D: Clinical records indicate the IDT/IDG care plans are developed, reviewed periodically and updated for each patient. (HI.2h)

D,I,O: A process exists for the regular review and revision of policies and procedures that show evidence of incorporation of new information. (HI.2i)

D: Staff meeting minutes (when available) include evidence of dissemination and updates of information. (HI.2i)

I: Managers verbalize process for incorporating new knowledge into systems. (HI.2i)

Hospice

HI.2h The IDT/IDG is responsible for:

1. **Participating in the establishment of the plan of care.**
2. **Participating in the periodic review and updating of the plan of care for each individual receiving hospice care.**
3. **Directing, coordinating and supervising hospice care and services.**
4. **Establishing policies and procedures governing the day to day provision of hospice care and services.**

HI.2i Systems exist for obtaining and integrating the most current standards of practice and communication into service delivery and policies and procedures and are used in planning, evaluation, and decision making in all aspects of end of-life care.

LEGEND:

D - DOCUMENTATION
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S - SURVEY

HI.3

D: **A current organizational chart is available and clearly delineates the lines of authority and accountability for all organizational positions down to the patient care level and across all continuums of care. (HI.3)**

Hospice

HI.3 Intra-organizational relationships of the Hospice Organization are clearly defined in writing

HI.3a A current organizational chart delineates the lines of authority and accountability for the delegation of responsibility of all personnel/employees down to the patient care level across all continuums of care provided and services professionally managed.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HI.4

D: **The hospice administrator's resume, reference checks and diploma(s) verify compliance with knowledge, experience and ability requirements. (HI.4a)**

D: **There is evidence that the hospice administrator was appointed by the governing body. (HI.4b)**

D: **A performance appraisal tool is available and utilized in evaluating the hospice administrator by the governing body or designee, if not the chief executive. (HI.4b)**

D: **The hospice administrator's defined responsibilities include the elements in HI.4c.**

I: **The hospice administrator can describe respective areas of responsibility. (HI.4c)**

I: **Management staff can describe the role of the administrator. (HI.4c)**

O: **The hospice administrator demonstrates through actions, an understanding, recognition and fulfillment of responsibilities. (HI.4c)**

Note: HI.4 may appear to be a duplication of CI.4; however, CI.4 pertains to the CEO of the organization, and HI.4 pertains to the Hospice Program Administrator, which may be the same or separate positions.

Hospice

HI.4 **A qualified professional is responsible for the direction, coordination and general supervision of all hospice services.**

HI.4a **The Hospice Service Administrator is a health care/human services professional with at least two (2) years of health-related experience, knowledge, and ability to effectively administer the Hospice Service.**

HI.4b **The Hospice Service Administrator, appointed by the Governing Body, is a hospice employee and is responsible for the day to day direction, coordination and general supervision of the Hospice Service.**

HI.4c **The Hospice Service Administrator is responsible for the overall management and direction including:**

1. **Operational organization planning and budgeting**
2. **Insuring organizational compliance with legal, regulatory and accreditation requirements**
3. **Monitoring business operations to ensure financial stability**
4. **Evaluating Hospice services and personnel using measurable outcomes and objectives**
5. **Conflict and complaint management/resolution**
6. **Establishing and maintaining effective channels of communication including integration of technology, as applicable**
7. **Insuring Hospice personnel stay current with clinical information and practices**
8. **Insuring adequate and appropriate staffing**
9. **Staff development including orientation, in-service, continuing education, competency testing and performance improvement**
10. **Insuring that interdisciplinary care is provided**
11. **Insuring supportive services are available to staff**
12. **Insuring coordination with other organization areas and senior management, as appropriate, according to the structure and services**
13. **Insuring staff and organization stay current on local and national issues and trends**
14. **Insuring that appropriate service policies and procedures are developed and implemented to accomplish identified outcomes**
15. **Directing staff in performance of their duties including admission, discharge, transfer, revocation and provision of service to patients**
16. **Insuring appropriate staff supervision during all service hours**
17. **Monitoring service utilization to ensure delivery of comprehensive care**
18. **Insuring services provided by other agencies are authorized by hospice**
19. **Monitoring operational progress toward accomplishing operational and strategic goals**
20. **Insuring appropriate data collection and regular, complete reports are received by the governing body**
21. **Insuring adequate space, equipment and supplies are available**
22. **Insuring actionable objectives are derived from evaluation of Hospice services and personnel**
23. **Insuring that structure and systems promote interdisciplinary care**
24. **Insuring collaboration with agencies and vendors for effective management of services**
25. **Insuring standards of ethical business and clinical practice are maintained**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HI.4 cont'd

D: **Job description delineates responsibilities and/or other written guidelines outline responsibilities as specified in elements 1-25 in HI.4c.**

D,I,O: **Document review, interview and observation validate that hospice retains professional management responsibility for services provided under arrangement. (HI.4d)**

D: **Written policy and procedure defines assignment of administrative responsibilities in the absence of the Hospice Service Administrator. (HI.4e)**

I: **Designated alternate to the Administrator understands his/her role and describes experiences specific to the alternate roles. (HI.4e)**

Hospice

HI. 4d Qualifications for administrative and management positions are clearly defined in writing and are consistent with the scope of responsibility and the complexity of the organization.

1. The Hospice Organization retains professional management responsibility for services when care is provider under arrangement/contract.

HI.4e A qualified individual is designated in writing to act in the absence of the Hospice Service Administrator.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HI.5

D,I,O:	**Review of policies, observation of staff, and interview with staff confirm that policies accurately reflect staff practice. (HI.5a)**
D:	**Hospice administrative policies and procedures are available and at a minimum address items 1-5. (HI.5b)**
D:	**Hospice clinical policies and procedures are available and at a minimum address items 1-27. (HI.5c)**

Hospice

HI.5 **Hospice-specific policies and procedures reflect an emphasis on quality and ethical practice, relate directly to the mission and scope of service of the Hospice program, and ensure patient rights and ethical standards of business and clinical practice.**

HI.5a **Organizational literature, policies and procedures accurately reflect the current practice, current professional standards of care and mission/scope of the Hospice program.**

HI.5b **Hospice administrative policies are written and include:**

1. **Patient informed consent/authorization**
2. **Hospice Payment Options**
3. **Election/revocation of Medicare Hospice Benefit**
4. **Discharge from Hospice Care**
5. **Change of Designated Hospice**

HI.5c **Clinical policies and procedures are written and define the process for accessing, planning, delivering and evaluating hospice care and services.**

Policies include at a minimum:

1. **Determination of appropriateness for hospice**
2. **Patient's Rights and Responsibilities**
3. **Development, review and revision of comprehensive plan of care**
4. **Receipt and processing of verbal orders**
5. **Initial/ongoing development of Interdisciplinary plan of care**
6. **Performance Improvement/comprehensive self-assessment of quality and appropriateness of care provided (inpatient, home care and care under arrangement)**
7. **Admission Criteria for:**
    a) **Hospice**
    b) **General inpatient level of care**
8. **Supervision of paraprofessional & volunteer services**
9. **Medication regime management**
    a) **Administration**
    b) **Control of narcotics in home, hospital, other facilities**
    c) **Disposal of controlled drugs in home, hospital, other facilities**
10. **Advanced Directives**
11. **Reporting abuse, neglect, fraud, or exploitation of patients**
12. **Patient safety**
13. **Pain Management**
14. **Clinical laboratory test procedures/processes, as applicable**
15. **Annual program evaluation**
16. **Written consent for release of information**
17. **Certification of eligibility**
18. **Contracted services**
19. **Interdisciplinary Group**
20. **Availability of Services 24 hours per day**
21. **Transfer criteria for level of care, transitional programs**
22. **Medical Emergencies protocol**
23. **Bereavement Program/Services**
24. **Verification of licensure of attending physician**
25. **Post Mortem Procedures per federal, state, local laws, regulations and codes**
26. **Clinical record retention post discontinuation of operations**
27. **Assessment of Clinical Skills and Competencies**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HI.5 cont'd

D: **Additional hospice policies and procedures are available and at a minimum address items 1-10. (HI.5d)**

D: **Review of record retention policies and discharged stored records confirms that clinical records are retained consistent with requirement. (HI.5e)**

Hospice

HI.5d Additional hospice policies and procedures:

1. **Define a mechanism for informing the patient about hospice care, including services of IDT/IDG, with registered nurse as the case manager/coordinator**

2. **Ensure that services are available within the hospice's defined geographic area**
3. **Define the criteria for transfer to another hospice, level of care or use of transitional programs such as a home health agency.**
4. **Define the referral and transfer process for patients whose needs cannot be met by the hospice or who request to transfer to a different hospice provider.**
5. **Include protocols for assessment of need and appropriate use of protective devices (e.g., restraints or seclusion) and immobilization as applicable per requirement specified in CFR 42 418.110 (m)**
6. **Include protocols for restraint or seclusion staff training requirements as specified in CFR 42.**
7. **Define process for staff to request not to participate in aspects of care when faced with conflicting cultural, ethical, or religious beliefs**
8. **Define mechanisms for assuring that the integrity of decision making is not endangered when the organization provides incentives to its staff, financial or otherwise**
9. **Define a system of communication and integration for coordination of services.**
10. **Design a process for the development of discharge criteria, discharge planning and the discharge process for hospice, including the requirement of a written physician order prior to discharge from hospice.**

HI.5e Clinical patient records are to be retained for 6 years after the death or discharge of the patient unless State law stipulates a longer period of time.

Hospice

HII.

THE HOSPICE SERVICE ORGANIZATION CONSISTENTY PROVIDES HIGH QUALITY SERVICES AND PRODUCTS

LEGEND:

D - DOCUMENTATION
I - INTERVIW
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S - SURVEY

HII.1

D:	**The Client Bill of Rights and/or other admission documents includes the elements specified in HII.1a1, 2, and 3.**

Hospice

HII.1 The mission and scope of services drives the activities of the Hospice Organization and ensures public disclosure, patient rights, and ethical standards of business and clinical practice.

HII.1a During the initial assessment visit in advance of furnishing care, the patient/family is informed both verbally and in writing of patient's rights and responsibilities pertaining to hospice care.

1. **The patient has the right to exercise his or her rights as a patient of hospice which includes the right to:**

   a) **Have his or her property and person treated with respect.**
   b) **Voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice and to not be subjected to discrimination or reprisal for exercising his or her rights.**
   c) **Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.**
   d) **Be involved in developing his or her hospice plan of care**
   e) **Refuse care or treatment**
   f) **Choose his or her attending physician**
   g) **Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.**
   h) **Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.**
   i) **Receive information about the services covered under the hospice benefit.**
   j) **Receive information about the scope of services that the hospice will provide and specific limitations on those services.**
   k) **Be advised that the Hospice Organization complies with Subpart 1 of 42 CFR 489 and receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and how such rights are implemented by the organization.**
   l) **Receive written information describing the organization's grievance procedure which includes the contact information, contact phone number, hours of operation, and mechanism(s) for communicating problems**
   m) **Receive an investigation by the organization of complaints made by the patient or the patient's family or guardian regarding treatment or care and that the organization will document the existence of the complaint and the resolution of the complaint.**
   n) **Receive information addressing any beneficial relationship between the organization and referring entities.**

2. **The patient has the right to expect that hospice will:**

   a) **Protect and promote the patient's right to exercise the rights**
   b) **Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator.**
   c) **Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified.**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.1 cont'd

D: **The Client Bill of Rights and/or other admission documents includes the elements specified in HII.1a1, 2 and 3.**

D: **Record review documents that a signed receipt of a copy of the notice of patient rights and responsibilities is obtained for every hospice patient and that the signature is executed in compliance with signatory requirements. (HII.1a.3, HII.1a.4)**

I: **Patient and/or family member confirms that hospice patient's rights and responsibilities were explained to patient/caregiver prior to signing verification of receipt of patient's rights. (HII.1a3,4)**

D: **Policy and plan is available consistent with requirements of HII.1b.**

I: **Management describes the process and plan for continuity of care in event of patient financial hardship. (HII.1b)**

HII.1a cont'd

d) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency.

e) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.

3. The rights of the patient are executed by the patient or designee as follows:

1. If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf.

2. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.

4. The hospice secures the signature of the patient or patient's representative confirming that he or she has received a copy of the notice of rights and responsibilities.

HII.1b The Hospice program does not discontinue or reduce care provided to a Medicare or Medicaid beneficiary patient because of the beneficiary patient's inability to pay for that care.

1. The Hospice organization has a plan for maintaining continuity of care in the event of a patient's declining or lack of financial resources.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.2

D: Access to all levels of care is documented in clinical record, as appropriate. (HII.2)

I & O: Services provided directly by the hospice or through arrangements are identified. (HII.2)

I: Patient/family/caregiver able to identify mechanisms and criteria established to determine transfer to different levels of care. (HII.2)

D: Services are available on a 24-hour basis as specified in HII.2a3.

D: Additional services are available as specified in HII.2a4.

D: Level of care and services are provided according to the plan of care. (HII.2a5)

D: Continuous care provided is according to elements specified in HII.2a6.

D: Inpatient respite care provided is according to elements specified in HII.2a7.

D: Inpatient hospital care provided is according to elements specified in HII.2a8.

D: Written policies and procedures delineate admission criteria and need determinants for inpatient care. (HII.2a8)

D: Bereavement policies and procedures delineate services, including a minimum of 12-month follow-up. (HII.2a9)

D: Drugs, biologics, equipment and supplies are available as specified in HII.2a2, HII.2a3, HII.2a4.

D: Policies and procedures address counseling needs of patient/family/caregiver, including criteria for identifying patients/families at risk. (HII.2a10)

D: Coordination of transport services is documented in the clinical record. (HII.2a11)

Hospice

HII.2 The Hospice Organization provides services in accordance with organizational policies and procedures and ensures that appropriate services and products are available to all hospice patients/families, either directly or by arrangement, and include routine home care, general inpatient care, inpatient respite care, continuous care, counseling, bereavement services and community education.

HII.2a Hospice services and products include at least the following:

1. **Core hospice services include nursing services, medical social services, counseling, and physician services provided consistent with acceptable standards of practice.**
   a) **Nursing, medical social services and counseling are provided substantially directly by hospice employees**
   b) **Physician services may be contracted**
   c) **A hospice may use contracted staff or enter into an agreement with another Medicare hospice program to supplement hospice employees in order to meet the core service needs of patients under extraordinary or non-routine times as specified in CFR 418.64.**
   d) **Highly specialized hospice nursing services that are provided so infrequently may be provided under contract.**
2. **Additional hospice services are provided by physical therapists, occupational therapists, speech/language pathologists, home health aides, homemakers, dietitians, spiritual and bereavement support, pharmacists, and volunteers as well as short-term inpatient care and medical supplies that are consistent with accepted standards of practice and included in the plan of care.**
3. **Hospice nursing services, physician services, drugs and biologicals are routinely available 24 hours a day/7 days a week.**
4. **Other covered services are available on a 24-hour basis to the extent necessary to meet patient needs.**
   a) **Care that is reasonable and necessary for palliation and management of the terminal illness**
   b) **Care that is reasonable and necessary for the treatment of related conditions**
5. **Routine home visits are provided according to the plan of care, which includes scope and frequency**
6. **Continuous care is provided for up to 24 hours per day during periods of crisis and includes:**
   a) **A minimum of eight hours during a 24 hour period is available during periods of crisis and may include:**
      - **Nursing**
      - **Home Health Aide**
      - **Homemaker**
      - **Volunteer services**
   b) **One half of the total hours of care provided during each 24 hour period is provided by a registered nurse or a licensed practical nurse**
7. **Inpatient respite care is provided in a Medicare/Medicaid facility, on a short-term basis, to assist the family in its ability to provide continuing care.**
8. **The general inpatient level of care is arranged when the patient requires palliation for acute medical, pain control and respite purposes.**
9. **A planned program for bereavement services is offered for at least 12 months following the patient's death**
10. **Counseling is provided by qualified hospice professionals**
11. **Transport services are coordinated**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.2 cont'd.

D:	**Clinical records document services provided in accordance with the plan of care. (HII.2b)**
D:	**IDT/IDG and clinical records document the plan of care for each patient consistent with the three elements in HII.2c.**
D:	**Initial and revised care plans are consistent with assessment data. (HII.2c)**
D:	**The plan of care is reviewed at specified intervals. (HII.2c3)**
D:	**The content of the plan of care includes the four elements specified in HII.2d.**
D:	**Hospice service interventions address the 12 elements of HII.2e.**
I:	**Staff describes types of interventions. (HII.2e)**
I:	**Patient/family/caregiver verbalizes understanding of services and satisfaction with his/her role in providing care, treatment and other interventions. (H11.2e)**

Hospice

HII.2b The Hospice IDT/IDG retains professional management responsibilities for the provision of services, including inpatient care and ensures that they are furnished in a safe and effective manner.

1. **Services are:**
   a) **Ordered by a licensed physician**
   b) **Provided in accordance with the plan of care**
   c) **Delivered by qualified personnel in a manner that is consistent with accepted standards of practice**
   d) **Documented in the clinical record**
   e) **Monitored to ensure compliance with the plan of care**
2. **Exchange of information between the hospice staff and contract providers is documented**

HII.2c An individual written plan of care is established and maintained for each Hospice patient and family.

1. **The plan is established by the attending physician, the medical director or physician designee, and the IDT/IDG in collaboration with the patient/representative/primary caregiver prior to the start of care.**
2. **Care provided to an individual patient is in accordance with the plan of care**
3. **The plan of care is reviewed and updated at specified intervals by the attending physician, the medical director or physician designee and the IDT/IDG.**
   a) **The written plan is reviewed every 15 days or more frequently as dictated by the patient's condition.**
   b) **Review of the patient plan of care is documented**

HII.2d The content of the plan includes:

1. **An assessment of the individual's and family's needs**
2. **An identification of services to be provided including management of discomfort and symptom relief**
3. **A statement detailing the scope and frequency of services necessary to meet the patient's and family's needs**
4. **Determination of ability of the patient/family to safely self-administer drugs and biologicals to the patient in the home**

HII.2e Hospice service interventions include:

1. **An explanation of the palliative care focus at time of admission to service**
2. **Evaluation of the patient's/family's ability to provide care**
3. **Evaluation of the need for other services**
4. **Consultation with the team to develop and revise the written plan of care as indicated**
5. **Assisting the family in understanding changes in the patient's status related to the progression of end-stage disease**
6. **Insuring that informed consent, understanding of choices for care and expected outcomes are explained and understood by patient/family**
7. **Informing patient/family about their rights**
8. **Considering and respecting the patient's wishes when planning for the patient's care**
9. **Evaluating patient's/family's ability to understand information and caregiver routines**
10. **Teaching the family techniques for providing care**
11. **Assisting the patient in evaluation of personal spiritual needs**
12. **Informing the patient of the availability of spiritual counseling in accordance with religious preferences or definition of spirituality**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
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S - SURVEY

HII.2 cont'd.

D:	**Tools such as the Medical Guidelines for Determining Prognosis in Selected Non-Cancer Disease are used to help identify patients with a life-limiting illness. (HII.2f)**
D:	**Care plan and documentation of interventions reflect IDT/IDG treatment of undesirable symptoms as specified in the 5 elements of HII.2f.**
D:	**Clinical record shows evidence of regular pain assessments and measures taken to achieve pain control. (HII.2g)**
I:	**Clinical staff and patients verbalize understanding of pain control measures and progress toward controlling pain. (HII.2g)**
D:	**Clinical record documents psychosocial assessment, including the three elements in HII.2h.**
D:	**Policies/procedures/protocols for working with psychosocial problems exist. (HII.2h)**
I:	**Staff verbalizes the importance of psychosocial assessment tools that facilitate interventions related to end of life, as well as issues identified by the patient as important and relevant. (HII.2h)**
I:	**Staff describes steps taken with evidence of suicidal ideation. (HII.2h2)**

Hospice

HII.2f The IDT/IDG treats and prevents undesirable symptoms of the patient's disease and/or co-morbidity factors based on a comprehensive assessment.

1. **Information documenting the patient's terminal illness is obtained at the time of the referral for hospice care.**
2. **The initial comprehensive assessment includes:**
   a) **A description of the patient's symptoms**
   b) **Pertinent medical history, medication and allergy history**
   c) **Common co-morbid conditions (initial and ongoing nursing assessments)**
3. **The plan of care is based on the initial assessment and is updated as appropriate**

HII.2g Pain assessment is a distinct, easily identifiable, part of the initial assessment and incorporated into other documentation tools.

1. **An initial pain assessment is completed on every patient admitted for service**
2. **The patient's preferences for pain management are reflected in the pain control measures selected**
3. **Procedures and protocols for pain assessment and management are developed and implemented, using a numerical or other rating scale for pain assessment**
4. **Patient/families are educated about the use and side effects of analgesic and/or adjuvant medications and expected responses to therapy**
5. **Non-pharmacological interventions are considered for the treatment of pain**
6. **Common side effects of medications are anticipated, and preventive measures are implemented**
7. **Specific protocols/procedures are in place for reassessing patients who rate their pain above a specific number (e.g., above 2 on a 0 - 5 scale), or who state that their pain is unacceptable**

HII.2h A thorough psychosocial assessment is initiated at the time of admission and continued throughout the course of care. Interventions to assist the patient are based on assessment data.

1. **The psychosocial assessment includes:**
   a) **An evaluation of the patient's preferred style of communication, including expressing emotions, feelings, thoughts and needs**
   b) **An evaluation of the patient's mental health needs**
   c) **An identification of substance abuse symptoms**
2. **A finding of suicidal ideation results in planning and interventions**
3. **Issues related to patient coping are assessed and addressed by the IDT/IDG and include at a minimum:**
   a) **Access to adequate and accurate information**
   b) **Change in family roles**
   c) **Communication abilities**
   d) **Ability to fulfill desired sexual expression**

LEGEND:

D - DOCUMENTATION
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HII.2 cont'd.

D:	**Care plans and clinical records document IDT/IDG efforts delineated five elements of HII.2i.**
D:	**Available literature explains what to expect during the dying process for the patient/family/caregiver (e.g., signs and symptoms of approaching death). (HII.2i)**
D:	**Chaplain or family describes patient affirmation of faith or resolution of spiritual issues. (HII.2i)**
I:	**IDT/IDG members describe patient/family experiences as delineated in HII.2i.**
D:	**Clinical record documents preparation and support of patient for death by staff and volunteers. (HII.2j)**
D:	**On-call services support the ability for staff attendance at all deaths in all settings. (HII.2j)**
D:	**A consistent procedure is evident for documenting each patient death and related communications. (HII.2j)**
I:	**Staff describes education of family members as death approaches and support measures to assist family/caregiver to continue care at home. (HII.2j)**
I:	**Staff describes notification procedures provided to family/caregiver before death occurs. (HII.2j)**
I:	**Nurse describes attendance and when state law allows, verification, of a patient's death. (HII.2j)**
O:	**Patient/family/caregiver educational materials including information about the psychological aspects of a terminal illness are evident during home visits. (HII.2j)**
D & I:	**Staff describes referral of patients/families to the hospice's after-hours telephone number and reasons to not give staff's own telephone numbers. (HII.2k)**
I:	**Staff explains importance of maintaining boundaries and describes techniques for avoiding over involvement with patient/family/caregiver. (HII.2k)**
D:	**Job description and/or policies identify responsibilities of each discipline which are consistent with national clinical practice standards. (HII.2l-2w)**
D:	**The Plan of Care incorporates all applicable services delineated in HII.2l through HII.2w.**

Hospice

HII.2i The IDT/IDG assists the patient/family to identify areas of importance in achieving reconciliation and closure with self, family, friends and community.

1. **IDT/IDG members promote the patient's acceptance of own strengths and unique qualities**
2. **Levels of support and nurturing are increased or modified in consideration of patient preferences as death approaches**
3. **The IDT/IDG facilitates communication between the family and the patient by encouraging expressions of love, concern, regret and forgiveness, as appropriate**
4. **Family members are taught the physical and psychological aspects of the dying process**
5. **Spiritual counselor facilitates affirmation of faith or spiritual beliefs as patient indicates**

HII.2j Preparation and support for the patient's death is provided.

1. **IDT/IDG members are available to attend patient deaths 24 hours a day, 7 days a week**
2. **Staff attending a death event respect the cultural and religious traditions and beliefs of the patient/family**
3. **Patient deaths are legally pronounced in accordance with state regulation and organizational policy and procedure**
   a) **Adherence to local/state/federal law is ensured**
   b) **Specifics of the death event are documented in the clinical record**
   c) **Required information is communicated/submitted to appropriate parties**
4. **The patient's body is handled with respect and dignity and in accordance with individual patient/family requests**
5. **Post mortem care is provided by in-patient staff in compliance with hospice policy and procedures.**

HII.2k Staff recognize and maintain professional boundaries in their relationships with the patient/ family/caregiver.

1. **Orientation, in-service and/or continuing education stress importance of maintaining professional boundaries with patient/family/caregiver**
2. **The IDT/IDG provides ongoing support for and techniques to avoid overstepping boundaries**

HII.2l Nursing services are provided in accordance with a plan of care.

1. **Nursing services are provided in accordance with accepted standards of practice by or under the supervision of a Registered Nurse.**

2. **Professional nursing service is provided by a Registered Nurse and includes:**

   a) **Initial and ongoing assessment of the impact of the terminal diagnosis on the patient's physical, functional, psychosocial and environmental needs and activities of daily living.**
      1) **Risk for pathological grief**
      2) **Cultural and spiritual implications**
      3) **Verbal and non-verbal communication patterns**
   b) **Implementing the individualized plan of care and recommending revisions to the plan as necessary.**
      1) **Managing discomfort and providing symptom relief**
      2) **Specialized nursing skills related to palliative and end-of-life care**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.2 cont'd.

D: **Job description and/or policies identify responsibilities of each discipline which are consistent with national clinical practice standards. (HII.2l-2w)**

D: **The Plan of Care incorporates all applicable services delineated in HII.2l through HII.2w.**

I & O: **Interviews and home visits confirm staff understanding and fulfillment of responsibilities. (HII.2l–2w)**

D: **Clinical record documentation by respective disciplines verifies fulfillment of assigned responsibilities. (HII.2l-2w)**

D: **Clinical record and plans of care document coordination of services, referrals as appropriate, and provision of palliative care for symptom management. (HII.2l-2w)**

D: **Documentation indicates ongoing instructions and support to primary caregivers and response to instruction. (HII.2l-2w)**

D: **Supervisory home visits are documented. (HII.2l.2j)**

D: **Job description, policies, protocols, state law and credentials are present and in compliance, if applicable. (HII.2l.3)**

c) Consulting with and educating the patient/family regarding:
    1) The disease process
    2) Self-care techniques
    3) End-of-life care
    4) The processes for dealing with issues of ethical concern
d) Initiating appropriate preventive and rehabilitative nursing procedures
e) Preparing clinical and progress notes that demonstrate progress toward established goal(s)
f) Coordinating all patient/family services and prioritization of needs with the members of the interdisciplinary team
g) Use of case management approach and referring to other services as needed
h) Informing the physician and other personnel of changes in the patient's needs and outcomes of intervention
i) Determining scope and frequency of services needed based on acuity and patient/family needs
j) Supervising LPNs/LVNs and paraprofessionals providing services to the patient according to regulatory guidelines
k) Participating in in-service programs
l) Providing specialized hospice training to other staff, family members and informal caregivers to ensure adequate care
m) On-going evaluation of patient/family response to care
n) Assessing the ability of the caregiver to meet the patient's immediate needs upon admission and throughout care
o) Evaluating own needs for support and using identified system(s) to meet the need
p) Applying specific criteria for admission and re-certification to hospice care to establish appropriate levels of care and the patient's eligibility
q) Communicating information using current process and technology available to the organization
r) Participating in the hospice performance improvement program

3) Professional nursing service may also include seeing, treating and writing orders for hospice patients if State law permits the registered nurse who is qualified to do so.

4) The LPN/LVN supplements the nursing care needs of the patient as provided by the RN and as specified in the plan of care including:

a) Providing services in accordance with organizational policies and procedures and regulations that define scope of practice
b) Preparing clinical and progress notes documenting outcomes of interventions
c) Assisting the RN and/or physician in performing specialized duties related to end-of-life care
d) Assisting the RN in carrying out the plan of care
e) Preparing equipment and materials for treatment adhering to aseptic technique as required
f) Assisting the patient in learning appropriate self-care techniques
g) Assessing patient/family response to care
h) Ensuring communication of information to appropriate team members

LEGEND:

D - DOCUMENTATION
I - INTERVIW
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S - SURVEY

HII.2 cont'd.

D: **Job description and/or policies identify responsibilities of each discipline which are consistent with national clinical practice standards. (HII.2l-2w)**

I & O: **Interviews and home visits confirm staff understanding and fulfillment of responsibilities. (HII.2l–2w)**

D: **Clinical record documentation by respective disciplines verifies fulfillment of assigned responsibilities. (HII.2l-2w)**

D: **Clinical record and plans of care document coordination of services, referrals as appropriate, and provision of palliative care for symptom management. (HII.2l-2w)**

D: **Documentation indicates ongoing instructions and support to primary caregivers and response to instruction. (HII.2l-2w)**

D: **Patient care assignments for paraprofessionals are documented. (HII.2l.5a.)**

O: **Home visits confirm the Hospice Aide(s) are prepared to function competently as required by specific patient needs. (HII.2l.5a)**

O: **Home visits confirm the Homemaker(s) are prepared to function competently as required by specific patient needs. (HII.2l.5b)**

D: **If applicable, personnel record includes competency documentation by State (if regulated (HII.21.5))**

D: **Clinical record documents hospice coordination with the Medicaid Benefit. (HII.2l.6)**

HII.2l cont'd

5. The Hospice Aide and/or Homemaker function in a supportive relationship to professional disciplines and may function as an extension of these professional services with written instructions, appropriate supervision and specialized hospice training.
   The Hospice Aide meets the qualifications specified in 418.76 (a) (1) – (2).

   a) Hospice Aide responsibilities (ii) include tasks listed on the plan of care, (iii) permitted to be performed under State law by such Hospice Aide (iv) consistent with Hospice Aide training and sub elements 1-8.

      1. Providing care consistent with written instructions
      2. Assisting with personal hygiene
      3. Assisting with ambulation and exercise
      4. Assisting with medications that are ordinarily self-administered
      5. Reporting changes in the patient's condition and needs to a registered nurse
      6. Providing nutritional support
      7. Performing other related supportive tasks as specified by organizational policy
      8. Completing appropriate records in compliance with hospice policies and procedures.

   b) Homemakers (environmental support staff, chore services staff and others who do not provide direct patient care) provide patients with environmental support under professional supervision and report all concerns to a member of the IDT.

6. An individual may provide Medicaid personal care aide-only service on behalf of a hospice agency if the requirements are met as specified in 418. 76 (i) (1) – (3).

HII.2m Rehabilitative services (PT, OT) are provided in accordance with the plan of care as reviewed and approved by the IDT/IDG.

1. All services are provided in accordance with accepted standards of practice by or under the direction of a qualified physical therapist, or occupational therapist as appropriate

2. Rehabilitative services (PT, OT) provided include, but are not limited to:
   a) Documentation of all therapy interventions
   b) Initial and ongoing assessment and evaluation of patient/family response to therapy
   c) Problem identification
   d) Goal setting related to needs of hospice patient
   e) Treatment planning in consultation with the physician and the IDT/IDG to achieve goals
   f) Treatment provision
   g) Development and revision of plan of care as indicated
   h) Consultation with IDT/IDG members
   i) Patient/family education
   j) Provision of equipment required to increase the patient's function and independence
   k) Timely recording of all assessment and evaluation data, treatments and patient's response to therapy intervention
   l) Education and consultation with patients/families and with organizational staff
   m) Provision of specialized hospice training
   n) Discharge planning and evaluation
   o) Supervision of therapy assistants and home health aides when appropriate
3. Rehabilitative Therapy Assistant (PTA, COTA) duties are performed in accordance with accepted standards of practice and under the supervision of a qualified physical therapist or occupational therapist. Services include:

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.2 cont'd.

D: **Job description and/or policies identify responsibilities of each discipline which are consistent with national clinical practice standards. (HII.2l-2w)**

I & O: **Interviews and home visits confirm staff understanding and fulfillment of responsibilities. (HII.2l–2w)**

D: **Clinical record documentation by respective disciplines verifies fulfillment of assigned responsibilities. (HII.2l-2w)**

D: **Clinical record and plans of care document coordination of services, referrals as appropriate, and provision of palliative care for symptom management. (HII.2l-2w)**

D: **Documentation indicates ongoing instructions and support to primary caregivers and response to instruction. (HII.2l-2w)**

a) Provision of patient care services which have been delegated by the therapist
b) Participating in preparing clinical and progress notes
c) Participating in educating the patient/family
d) Participating in in-service programs
e) Assessing patient/family response to therapy
f) Communication of information to appropriate IDT/IDG members

HII.2n Speech-language pathology and audiology services are provided in accordance with a plan of care, reviewed and approved by the IDT/IDG.

1. **All services are provided in accordance with accepted standards of practice and by or under the direction of a qualified Speech Language Pathologist (SLP) or Audiologist.**
   Services include:

   a) Testing and recommending mechanisms which focus on such interventions as alternative methods of communication/speech and swallowing exercises to help with nutrition
   b) Ongoing assessment, evaluation and documentation of patient's level of functioning and hearing in response to therapy
   c) Recommending appropriate inter and intra-agency referrals
   d) Developing the plan of care in consultation with the physician and the IDT/IDG members
   e) Goal setting based on the needs of the hospice patient/family
   f) Education and consultation with the patient/family and other organizational personnel
   g) Discharge planning, as appropriate
   h) Participating in in-service programs, as appropriate
   i) Communicating information to IDT/IDG members

HII.2o Medical Social Services are provided by a qualified social worker under the direction of a physician and in accordance with a plan of care.

1. **All services are provided by a qualified social worker (BSW or MSW)**
2. **Medical Social Services include:**
   a) Assessing emotional factors related to terminal illness
   b) Assisting the physician and other IDT/IDG members in recognizing and understanding the social/mental stress and/or disorder that exacerbates the symptoms related to terminal illness
   c) Assessing the patient/family psychosocial status, potential for risk of suicide and/or abuse or neglect
   d) Assessing environmental resources and obstacles to maintaining safety
   e) Participating in the development and revision of the plan of care
   f) Providing social services including:
      a. Short-term individual counseling
      b. Crisis intervention
      c. Assistance in providing information and preparation of advance directives
      d. Funeral planning issues and transfer of responsibilities regarding fiscal, legal and health care decisions
   g) Preparing clinical and progress notes
   h) Identifying family dynamics and communication patterns
   i) Involving the patient/family in the plan of care
   j) Identifying and utilizing appropriate community resources and assessing patient/family ability to access them

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.2 cont'd.

D: **Job description and/or policies identify responsibilities of each discipline which are consistent with national clinical practice standards. (HII.2l-2w)**

I & O: **Interviews and home visits confirm staff understanding and fulfillment of responsibilities. (HII.2l–2w)**

D: **Clinical record documentation by respective disciplines verifies fulfillment of assigned responsibilities. (HII.2l-2w)**

D: **Clinical record and plans of care document coordination of services, referrals as appropriate, and provision of palliative care for symptom management. (HII.2l-2w)**

D& O: **A hospice physician/Medical Director participates in determining admission and consults with attending physician, as needed. (HII.2q)**

k) Participating in-service programs
l) Evaluating patient/family response to psychosocial interventions
m) Assessing caregiver's ability to function adequately
n) Assessing need for counseling related to risk assessment for pathological grief
o) Assessing special needs related to cultural diversity including communication, space, role of family members and special traditions
p) Identifying the developmental level of patient/family and obstacles to learning or ability to participate in care of patient
q) Addressing patient/family questions and issues
r) Identifying obstacles to compliance and assisting in understanding goals of interventions
s) Identifying support systems available to reduce stress and facilitate coping with end-of-life care
t) Evaluating for long-term care when appropriate and assessing ability to accept change in level of care
u) Communicating psychosocial information to inpatient facility when level of care is changed
v) Assisting patient/family in assessing financial resources when appropriate
w) Identifying patient/family needs when discharged or when level of care changes
x) Evaluating patient/family response to intervention(s) when referred to community agency and satisfaction of the service(s) provided
y) Assessing bereavement needs

HII.2p Dietary counseling is available and provided on an intermittent basis, as indicated in accordance with the plan of care.

1. Interventions are incorporated into the plan of care, reviewed and approved by the IDG/IDT
2. All services are provided by or under the direction of a Registered Dietitian, a nurse or a qualified individual and include:
   a) Assessing the nutritional needs of patients upon request
   b) Determining the effectiveness of medically prescribed diet(s)
   c) Teaching patients/families and staff special dietary regimens and nutritional requirements as appropriate to diagnosis and individual preference
   d) Documenting patient care in the clinical record
   e) Identifying factors relating to variances of weight and/or size
   f) Attending IDT/IDG care meetings as appropriate
   g) Providing in-service education to hospice staff and educational tools for patient/family
   h) Providing counseling to adapt diet to the patient's changing status
   i) Consulting with the IDT/IDG members and/or RN
   j) Assessing patient/family response to care
   - Access to food/nutritional supplements
   - Ability to prepare food
   - Adequate tools and space
   - Nutritional risk

   k) Collaborating with the nursing staff in applying a nutritional risk assessment to:
   - Determine the need for a mechanically altered diet
   - Assess the effect of end stage disease on hydration and nutrition

HII.2q Physician services are provided by the Medical Director of the hospice, physician employees, and contracted physicians of hospice in conjunction with the attending physician.
Services include:

1. Palliation and management of terminal illness and conditions related to the terminal illness

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.2 cont'd.

D: **Job description and/or policies identify responsibilities of each discipline which are consistent with national clinical practice standards. (HII.2l-2w)**

I & O: **Interviews and home visits confirm staff understanding and fulfillment of responsibilities. (HII.2l–2w)**

D: **Clinical record documentation by respective disciplines verifies fulfillment of assigned responsibilities. (HII.2l-2w)**

D: **Clinical record and plans of care document coordination of services, referrals as appropriate, and provision of palliative care for symptom management. (HII.2l-2w)**

D: **The Medical Director's resume, current license, reference checks and diploma(s) verify compliance with education and experience requirements. (HII.2r, HII.2r.1)**

D: **The Medical Director's job description delineates responsibilities. (HII.2r.2-3)**

D: **The Hospice Medical Director provides oversight of physician services as specified in the five elements of HII.2r.2.**

D: **Evidence of Hospice Medical Director's compliance with the 18 sub-elements of HII.2r.3 is available in clinical records, minutes of the IDT/IDG, and documentation of in-services provided. (HII.2r.3)**

D & O: **A hospice physician/Medical Director participates in the IDT/IDG meetings. (HII.2r)**

I: **Medical Director and staff describe Medical Director's role. (HII.2r)**

I: **Medical Director and other hospice employees describe Medical Director's supervisory process. (HII.2r.2b)**

Hospice

2. **Medical care interventions targeting unmet general medical needs**
3. **Hospice Pre-election Evaluation and Counseling Services**

HII.2r The Medical Director is a licensed physician (a Doctor of Medicine or Osteopathy) who organizes and assumes overall responsibility for the medical component of the hospice's patient care program. When the Medical Director is not available, a physician designated by the hospice assumes the same responsibilities as the Medical Director.

1. **The Medical Director is Board Certified in a related specialty and:**
   a) **Has expertise in the medical care of terminally ill individuals**
   b) **Is employed full-time or part-time by the hospice or has a contractual arrangement that provides for comprehensive medical direction of hospice**

2. **The Hospice Medical Director provides oversight of physician services.**
   a) **Complements attending physician care**
   b) **Supervises all hospice physician employees and contract hospice physicians**
   c) **Acts as a medical resource person to the IDT/IDG**
   d) **Assures overall continuity of the hospice medical services**
   e) **Assures that the patient receives appropriate measures to control uncomfortable symptoms**

3. **The Medical Director or physician designee is responsible for:**
   a) **Collaborating with the IDT/IDG to ensure that the medical needs of the patient are met and providing oversight of the plan of care**
   b) **Certifying that the patient meets the medical criteria for hospice admission based upon available diagnostic and prognostic indicators, related diagnosis(es) if any, current subjective and objective medical findings, current medication and treatment orders, information about the medical management of any of the patient's conditions unrelated to the terminal illness.**
   c) **Collaborating with the patient's attending physician to develop and update the patient's plan of care, to identify needs not met by the attending physician, and to ensure pain and symptom management and control**
   d) **Re-certifying patients, as appropriate, for continuation of Medicare Hospice Benefit at appropriate levels of care**
   e) **Serving as a medical resource to hospice staff, patients, families, and attending physicians regarding pain and symptom control management**
   f) **Insuring the provision of direct medical services to patients either directly or through arrangements, as appropriate, in the absence of the patient's attending physician**
   g) **Attending IDT/IDG conferences**
   h) **Participating in plan of care development and managing oversight of medications and treatment**
   i) **Documenting care provided in the patient's clinical record providing evidence of progression of the end-stage-disease process**
   j) **Maintaining current knowledge of the latest research and trends in hospice care and pain/symptom management**
   k) **Working in a team approach with the IDT/IDG**
   l) **Participating in performance improvement programs, as indicated**
   m) **Providing consultation and education to colleagues and attending physicians related to admission criteria for hospice and palliative care**
   n) **Reviewing and developing protocols for treatment and proposing the most current options for interventions**
   o) **Demonstrating knowledge in communications and counseling patient/family in**

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HII.2 cont'd.

D: **Job description and/or policies identify responsibilities of each discipline which are consistent with national clinical practice standards. (HII.2l-2w)**

I & O: **Interviews and home visits confirm staff understanding and fulfillment of responsibilities. (HII.2l–2w)**

D: **Clinical record documentation by respective disciplines verifies fulfillment of assigned responsibilities. (HII.2l-2w)**

D: **Clinical record and plans of care document coordination of services, referrals as appropriate, and provision of palliative care for symptom management. (HII.2l-2w)**

D: **Clinical record shows assessment of the patient/family/caregiver need for spiritual/pastoral counseling. (HII.2s.1)**

D: **Clinical record and IDT/IDG minutes indicate the patient's spiritual beliefs and traditions are supported by the IDT/IDG. (HII.2s.1)**

D: **Clinical record documents availability of community clergy when requested. (HII.2s.1)**

O: **Patients/families/caregivers describe support from the spiritual care counselor. (HII.2s.1)**

I & O: **Staff/volunteers describe bereavement assessment timing and process (i.e., at admission, periodically during the patient's hospice care and following the patient's death). (HII.2s.2)**

I & D: **Staff/volunteers and records describe and confirm bereavement counseling services to SNF/NF or ICF/MR, if appropriate. (HII.2s.2)**

D: **Clinical records and IDT/IDG minutes indicate appropriate counseling. (HII.2s.3)**

D: **Record of volunteer services and patient/family/caregiver response is available. (HII.2t)**

D: **Volunteer services follow a well-defined referral process. (HII.2t)**

p) dealing with end-of-life issues
q) Participating in resolution of interpersonal conflict and issues of clinical and ethical concern
r) Participating in the development and updating of patient care policies and emergency procedures
s) Acting as a liaison to physicians in the community

HII.2s Qualified counselors are available to the patient/family, hospice staff and volunteers, as needed, to assess and address the spiritual/pastoral, bereavement and/or the additional individual and/or group counseling needs.

1. Spiritual/Pastoral counseling services are provided in accordance with the plan of care and include:
   a) Spiritual/Pastoral assessment as indicated and appropriate, is completed as soon as possible after admission
   b) Spiritual/pastoral support is provided in accordance with on-going wishes and needs of the patient/family
   c) Development of an individualized spiritual/pastoral plan of care which:
      - Demonstrates an effort to work in close collaboration with local clergy whenever desired by the patient
      - Provides spiritual support as needed and defined by the patient/family
   d) Conducting religious services of prayer, worship and rituals for patients/families, as appropriate
   e) Offering patients/families of different philosophies and religious beliefs opportunities to discuss and share their thoughts, feelings, beliefs and values
   f) Documenting counseling provided in the patient's clinical record
   g) Working with other professionals in resolving spiritual/pastoral/ethical issues
   h) Working in a team approach with members of the IDT/IDG and other qualified professionals, as determined by the hospice, to evaluate patient/family response to care
   i) Attending IDT/IDG conferences when plan of care is reviewed
   j) Upon request, meeting with individual staff regarding personal spiritual/pastoral issues that may affect their ability to function effectively
   k) Assisting in developing and updating the plan of care
   l) Being available to staff for bereavement support
   m) Assessing patient/family response to and satisfaction with care
   n) Participating in development of approaches to meet staff counseling needs

2. Bereavement counseling services are provided in accordance with the plan of care under the supervision of a qualified professional with experience or education in grief or loss counseling.
   a) Bereavement staff make visits to the patient/family prior to death and are available to family during the bereavement period
   b) Bereavement counseling extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care.
3. Other counseling services are provided as determined appropriate by the IDT/IDG

HII.2t Volunteer services are provided to patients/families as part of the hospice IDT/IDG oversight responsibilities.

1. Defined volunteer activities are provided under the supervision of a designated hospice employee and in accordance with the plan of care.
2. Volunteer services include administrative or direct patient care roles and may include:
   a) Providing emotional support to patients/families

LEGEND:

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HII.2 cont'd.

D: **Job description and/or policies identify responsibilities of each discipline which are consistent with national clinical practice standards. (HII.2l-2w)**

I & O: **Interviews and home visits confirm staff understanding and fulfillment of responsibilities. (HII.2l–2w)**

D: **Clinical record documentation by respective disciplines verifies fulfillment of assigned responsibilities. (HII.2l-2w)**

D: **Clinical record and plans of care document coordination of services, referrals as appropriate, and provision of palliative care for symptom management. (HII.2l-2w)**

D: **Policies clearly identify services of the bereavement program. (HII.2u)**

D: **Bereavement follow-up is provided within identified time frames. (HII.2u)**

D: **Bereavement care plans are used routinely and adapted as needed. (HII.2u)**

D: **A means of communicating with out-of-area family members is developed to provide bereavement information and to offer support resources in their area, if desired. (HII.2u)**

D: **Community education program plans (as appropriate) include identification of goals and activities. (HII.2v)**

Note: Community Education activities may include information about access to care, the Medicare Hospice Benefit, advance directives, admission criteria, education and support of caregivers, bereavement services, and planning for end-of-life care. (HII.2v)

D & I: **A mechanism for receiving feedback and evaluation of community education programs is in place and used to modify and improve programs. (HII.2v)**

D & I: **Pharmacy services are available by employee pharmacist or via contract and include elements 1-9. (HII.2w)**

D: **Licensed pharmacist oversees drug control system in inpatient unit, which is defined in policies/ procedures/manual and is in compliance with elements in HII.2w.**

D: **Pharmacist describes interactions with staff, i.e., instructing and consulting activities. (HII.2w)**

Hospice

b) Providing personal care to patients
c) Providing relief to family caregivers
d) Assisting families with household chores
e) Attending IDT/IDG conferences, as appropriate
f) Reporting response of patient/family to hospice staff

3. Volunteer professional services are provided by professionals who meet the State regulations for the discipline.

HII.2u A bereavement program provides care for families and other individuals in the bereavement plan of care for at least one year following the death of the patient.

1. Bereavement policies and procedures define bereavement services, including:
   a) Maintenance of confidentiality
   b) Mechanisms to ensure that the family and caregiver's choices regarding bereavement contact or services are honored
   c) Services are provided by staff who have received training and have experience in dealing with grief
   d) Services are provided under the supervision of a qualified professional
2. Evaluation and assessment of grief needs and risk factors associated with grief
3. Assessment of family response to grief and loss issues
4. Development of a bereavement plan of care, reflecting family needs and frequency of services
5. Services are provided in accordance with a plan of care.

HII.2v Community education activities are provided and include goals, objectives and evaluation of educational activities.

HII.2w The hospice employs or contracts with a licensed pharmacist or pharmacy to meet the needs of the patients. In addition to ordering, administration, storage, disposal and record keeping of drugs and biologics, responsibilities include:

1. Overseeing the drug control systems including receipt of prescriptions, storage of medications, preparations of drugs, labeling of prescriptions, preparing of drugs for distribution and dispensing of medications prescribed by a physician
2. Providing 24-hour availability of drugs and biologics
3. Instructing patients and caregivers regarding specific drug therapy
4. Providing information regarding the safe and appropriate use of drugs to other health professionals
5. Identifying appropriate outcomes of drug therapy
6. Consulting on drug therapy and coordinating with the IDT/IDG
7. Monitoring and documenting ongoing drug therapy including the assessment of:
   a) Therapeutic appropriateness of the choice of drugs(s)
   b) Therapeutic duplication in the patient's drug regimen
   c) Appropriateness of the dose, frequency and route of administration
   d) Adherence to the drug regimen
   e) Potential drug, food or diagnostic test interactions or disease limitations to drug use
   f) Laboratory or clinical monitoring methods to detect drug effectiveness, side effects, toxicity or adverse effects
8. Pharmacy services are provided in compliance with federal and state laws
9. Patient identification is confirmed according to established policy

LEGEND:

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HII.3

D: **Policies and records indicate availability of needed services 24 hours per day and 7 days a week. (HII.3)**

D: **An established means of staff communication exists to insure the accurate and timely transfer of information on a daily basis. (HII.3)**

I: **Patient/family/caregiver is able to describe how to access services at all hours. (HII.3c, HII.3d)**

Hospice

HII.3 **Necessary hospice care is available 24 hours a day, 7 days per week.**

HII.3a **Physician services, nursing services including home visits, when needed, drugs and biologicals are available 24 hours a day/7 days per week.**

HII.3b **All other services are available 24 hours a day, 7 days per week to meet individual patient care needs including inpatient admission.**

HII.3c **Patient/family has communication accessibility to hospice staff during regular business hours and after hours.**

HII.3d **Patient/family understands how to access services.**

LEGEND:

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HII.4

D: **Written policy identifies admission criteria and referral process when the organization is unable to provide the needed service. (HII.4a)**

D: **Clinical records reflect congruence between policy and practice. (HII.4a)**

D & I: **Record review and interviews confirm that the patient/family, Medical Director, attending physician and IDT/IDG participate in determining the appropriateness to start hospice care. (HII.4b)**

D & I: **Clinical record review and interviews confirm that the registered nurse conducted an initial comprehensive assessment for each hospice patient which included all of the required elements and was completed within the timeframe specified in HII.4c and HII.4c.1-3.**

D: **Clinical record review confirms that the hospice IDT/IDG completed the initial comprehensive assessment for each hospice patient within 5 calendar days after the hospice election. (HII.4c)**

Hospice

HII.4 The Hospice Organization admits patients whose care needs can be met and ensures continuity of care through a comprehensive assessment and service coordination.

HII.4a Patients are admitted for hospice services based on the reasonable expectation that their physical, social, psychological and spiritual needs can be adequately met throughout the continuum of hospice services.

HII.4b Patient/family, Medical Director, attending physician and hospice IDT/IDG participate in determining the appropriateness to begin hospice care.

HII.4c An initial comprehensive assessment is completed by(a) the hospice registered nurse within 48 hours after the election of hospice care in accordance with 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.) (b) The hospice interdisciplinary group in consultation with the individual's attending physician(if any) must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with 418.24 and includes:

1. **Identification of patient/family/caregiver needs related to the terminal illness:**
   - **a) Physical**
   - **b) Psychosocial**
   - **c) Emotional**
   - **d) Cognitive**
   - **e) Cultural**
   - **f) Spiritual**
   - **g) Nutritional**
   - **h) Functional**
   - **i) Educational**
   - **j) Support and/or counseling**

2. **Consideration of other factors:**
   - **a) Nature and condition causing admission**
   - **b) Complications and risk factors affecting care planning**
   - **c) Functional status, including ability to understand and participate in care**
   - **d) Imminence of death**
   - **e) Severity of symptoms**
   - **f) Drug profile, including prescriptions, over-the-counter drugs, herbal remedies and alternative treatments which includes identification of:**
   - **g) Effectiveness of drug therapy**
   - **h) Drug side effects**
   - **i) Actual/potential drug interactions**
   - **j) Duplicate drug therapy**
   - **k) Drug therapy related to laboratory monitoring**
   - **l) Initial bereavement assessment of patient family's needs focusing on social, spiritual and cultural factors impacting ability to cope with patient's death**
   - **m) Need for referrals and further health professional evaluations**
   - **n) Ability of patient/family to self-administer drugs and biologicals in home**

LEGEND:

D - DOCUMENTATION
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HII.4 cont'd

D:	**Clinical records and aggregated reports document that uniform data elements are collected for each hospice patient at the time of the comprehensive assessment and aggregated for performance review and analysis. (HII.4c.3)**
I:	**IDT/IDG members describe process for integrating the data elements into the performance appraisal program and describe one example of the utilization of the aggregated data for improving a problem. (HII.4c.3c)**
D:	**Clinical records and IDT/IDG minutes document that updates of the comprehensive assessment are conducted at a minimum of every 15 days and include the specified elements. (HII.4d)**
D:	**Clinical records and IDT/IDG minutes document fulfillment of coordination responsibilities by nurses. (HII.4e)**
I:	**Case coordination responsibilities are recognized and assignment practices are identified. (HII.4e)**
I:	**Nurses describe responsibilities. (HII.4e)**
I:	**Hospice staff can identify referral and transfer procedures and give examples. (HII.4e.5)**
I & O:	**The treatment team demonstrates interdisciplinary participation and problem solving using assessed needs and actionable outcomes to develop and revise the care plan. (HII.4f)**
I:	**Team members verbalize their roles and contribution to team conferences. (H.II.4f)**
D:	**Clinical records and IDT/IDG minutes document fulfillment of staff responsibilities. (HII.4f)**
D:	**IDT/IDG minutes/records reflect physician oversight, participation and communication. (HII.4f.6)**

HII.4c cont'd

3. **Collection of uniform data elements that allow for measurement of patient outcomes.**
   a) **Assessment data elements include hospice and palliation care aspects**
   b) **Assessment data elements are measured and documented in a systematic and retrievable way for each patient**
   c) **Data elements are aggregated and integrated into the hospice performance appraisal program**

HII.4d **An update of the comprehensive assessment is conducted by the hospice interdisciplinary team in collaboration with the patient's attending physician (if any) as frequently as the patient's condition warrants but no less frequently than every 15 days and includes:**

1. **Identification of changes that have occurred since the initial assessment**
2. **Information on the patient's progress toward desired outcomes and goals**
3. **Reassessment of the patient's response to care.**

HII.4e **A registered nurse coordinates the implementation of the plan of care for each patient and is responsible for insuring the following:**

1. **Initial assessment of the patient/family and identification of risks and interventions on admission**
2. **Development of an initial plan of care with IDT/IDG input**
3. **Communication of findings to the attending physician, Medical Director and IDT/IDG members**
4. **Implementation of the plan of care with a focus on palliative care**
5. **Appropriate referral and follow-up**
6. **Care coordination and case management**
7. **Ongoing evaluation and assessment of the provision of hospice care for the patient and family**
8. **Recommending to the IDT/IDG modifications to the plan of care based on patient/family/caregiver response to hospice services**
9. **Facilitating the implementation of another level of hospice care when necessary**
10. **Utilization review**
11. **Assessment of risks associated with grieving**
12. **Communication between hospice and other health care providers**

HII.4f **The Interdisciplinary Team/Group reviews and updates the plan of care at least every 15 days during IDT/IDG conferences which include:**

1. **Reviewing new referrals relative to the need for and appropriateness of hospice care**
2. **Identifying obstacles to and solutions for access of care issues**
3. **Reviewing admissions and initial comprehensive assessments, insuring compliance with Hospice policies and procedures**
4. **Determining level of services required by the patient/family based on Hospice Team assessments**
5. **Developing, reviewing and modifying patient/family plans of care, as appropriate, considering:**
   a) **Changes in patient's clinical status**
   b) **Social, cultural and physical environments that may present obstacles to effective interventions**
   c) **Special needs of patient**
6. **Oversight of plan of care by the Medical Director**

LEGEND:

D - DOCUMENTATION
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HII.4 cont'd

D: **Clinical record review documents that the IDT/IDG reviews and updates the plan of care and that effective coordination occurs. (HII.4g)**

D: **Clinical record review documents that discharge summaries are completed for designated patients and include the specified elements. (HII.4h)**

D: **A review of records for patients transferred documents that appropriate documents were provided to the receiving facility. (HII.4i)**

D: **A review of records of patients discharged or who revoked hospice care documents that the appropriate documents were provided to the attending physician. (HII.4j)**

7. **Evaluating current services for their effectiveness**
8. **Evaluating the appropriateness of re-certification based on identifiable criteria and progression of end-stage disease**
9. **Planning for transfer, based on review of clinical data and patient/family choice, if change in level of care becomes necessary**
10. **Evaluating patient/family progress toward achievement of expected outcomes, and revising goals and objectives as needed**
11. **Evaluating pharmacotherapeutic effectiveness of symptom management outcomes including pharmacodynamics, pharmacokinetics and pharmacotherapies**
12. **Integration of alternative therapies into medical regime to assist in effectiveness**
13. **Determining need for, and coordinating bereavement services for family members**
14. **Monitoring changes that may contribute to risk for pathological grief**
15. **Reviewing discharge of the patient/family to ensure appropriateness of care**
16. **Reviewing deaths to retrieve information required to address bereavement needs**
17. **Assessing grievances and issues of ethical concern**
18. **Assistance with transfer and/or revocation of benefit**

HII.4g **The clinical record or minutes of the IDT/IDG document that the plan of care was reviewed and updated and that effective interchange, reporting and coordination of patient/family care occurs.**

HII.4h **A discharge summary is completed for each patient released from hospice service by discharge, transfer or revocation of the hospice care and includes:**

1. **A summary of the patient's stay including treatments, symptoms, and pain management**
2. **The patient's current plan of care**
3. **The patient's latest physician orders**
4. **Other documentation facilitating continuity of care and/or requested by the attending physician or receiving facility**

HII.4i **If a patient is transferred to another Medicare/Medicaid certified facility, a copy of the hospice discharge summary and a copy of the hospice clinical record (if requested) is sent to the receiving facility.**

HII.4j **If a patient revokes the election of the hospice care or is discharged from hospice, a copy of the hospice discharge summary and a copy of the hospice clinical record (if requested) is sent to the attending physician.**

LEGEND:

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HII.5

D:	**Record review confirms that written plans of care are signed by the attending physician, Medical Director or designee every 15 days for all patients. (HII.5a)**
D:	**Mechanisms for development/review/revision of plans of care including all appropriate care providers are described. (HII.5b)**
D:	**Plan of care is individualized and based on initial and updated comprehensive assessments and includes measurable goals and outcomes. (HII.5b)**
D:	**Plans of care are available for each patient and include the elements indicated. (HII.5c)**
D:	**Bereavement plan of care and support is documented. (HII.5d)**
I:	**Patient/family/caregiver verbalizes familiarity with plan of care and bereavement support. (HII.5c-d)**

Hospice

HII.5 An interdisciplinary care team/group (IDT/IDG) collaborates with patient's attending physician, patient/representative and primary caregiver to develop a patient directed individualized plan of care.

HII.5a Care is provided under the direction of the attending physician, Medical Director or physician designee in coordination with the IDT/IDG and follows a written plan of care reviewed a minimum of every 15 days.

HII.5b The interdisciplinary written plan of care is based on initial and updated patient-specific comprehensive assessments by members of the IDT/IDG and is developed with measurable goals and outcomes for planned interventions.

HII.5c The Hospice written interdisciplinary plan of care is developed and individualized for each patient and family, reflects patient/family goals based upon problems identified in the initial/updated assessments, and includes all services necessary for palliation and management of the terminal illness and related conditions, including the following:

1. **Participation by the patient/family/caregiver, based on ability and response to care**
2. **Reduction in risk factors**
3. **Individualized interventions to assist with end of life care**
4. **Placement at the appropriate level of care**
5. **Treatments, drugs and interventions to manage pain and symptoms**
6. **Medical supplies and appliances necessary to meet needs**
7. **Detail of the scope and frequency of services needed to meet the patient/family needs**
8. **Safety measures to protect against abuse, injury, infection or communicable disease, as appropriate**
9. **Appropriate authorities are informed as applicable**
10. **Referrals as needed for:**
11. **Counseling**
12. **Other disciplines**
13. **Volunteers**
14. **Adjunctive services**
15. **Victims of abuse/neglect/exploitation**
16. **Patient's/family/caregiver's ability to learn and to understand teaching**
17. **Patient's/family/caregiver's understanding, involvement and agreement with plan of care**
18. **Measurable outcomes anticipated**

HII.5d The Hospice bereavement plan of care is developed based on an assessment of the patient/family needs at the time of admission and during the provision of hospice care and when the patient dies and includes:

1. **Patient/family grief and/or loss issues**
2. **Survivor needs**
3. **Social, spiritual, and cultural issues**
4. **Services to be provided**
5. **Referrals to be made**
6. **Grief risk factors**
7. **Potential for pathological grief reactions**
8. **Individual counseling, support groups, letters and cards**

LEGEND:

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HII.5 cont'd.

D: Written instructions, prepared by the RN, are provided to the paraprofessional which details specific plan of care for each patient. (HII.5e)

D: Verbal orders are on the clinical record and reflect agency policy. (HII.5f)

D: Policies outline medication administration procedures and requirements. (HII.5g)

I: Staff describes and complies with medication administration policies. (HII.5g)

I: Staff describes attempts made to obtain necessary drugs, biologics, equipment, and supplies. (HII.5g)

D: Policies and procedures identify techniques to be used in the management and disposal of controlled drugs. (HII.5h)

D: Records document safe disposal of controlled drugs. (HII.5h)

I: Adherence to state, federal and local law is described (e.g., Nurse Practice Act, Drug Enforcement Administration, etc.). (HII.5h)

D & I: Records and patients document that a copy of the policy was received and discussed at time of initial drug order. (HII.5i)

D: Policies and procedures delineate criteria for medical supplies and appliances and ways to obtain required items. (HII.5j)

D: Protocols for meeting medical supplies and appliances are related to diagnosis and assessments with consideration for end of life care. (HII.5j)

I: Staff understands policies and requirement that hospice is responsible to provide all medical supplies, appliances, drugs, and biologics related to the patient's terminal diagnosis. (HII.5g, 5j)

I: Patients state that they have been instructed in the use of medical equipment and supplies. (HII.5j.1)

Hospice

HII.5e Written instructions for patient care, prepared by an RN , are provided to a home health aide or homemaker to ensure compliance with the patient's plan of care and are reviewed and updated at specified intervals per organizational policy.

HII.5f Verbal orders are received, processed, confirmed in writing and countersigned by the physician in accordance with state/federal laws and regulations.

HII.5g All drugs, biologicals and nutritional therapies are administered in accordance with accepted standards of practice.

1. Drugs and biologicals are administered by the following individuals:
a) A licensed nurse or physician
b) An employee who has completed a state approved training program in medication administration
c) The patient if the Interdisciplinary Group has granted approval for self-administration
- **Any other individual in accordance with applicable state and local laws/and as specified in the patient's plan of care**
- **Identity of authorized person(s)**

d) Drugs and biologics authorized to be administered
2. Drugs, biologicals and nutrition therapies are stored and distributed in accordance with acceptable standards, established by the manufacturer including temperature, light and length of time.

HII.5h Controlled substances are safeguarded in the home and disposed of in the home when such drugs are no longer needed by the patient.

1. Controlled drugs are those substances subject to the Controlled Substance Act of 1970 and are safeguarded in compliance with organizational policy.
2. Disposal of controlled drugs is accomplished in compliance with organizational policy and procedure and applicable state law

HII.5i Patients are provided a copy of the hospice policy on the management and disposal of controlled drugs in the patient's home at the time that the drug is first ordered.

1. The policy and procedure for managing safe use and disposal of controlled drugs is discussed with the patient or patient representative and family.
2. Hospice documents in the patient's record that the policy and procedure was provided and discussed.

HII.5j Medical supplies and appliances are provided as needed for the palliation and management of the terminal illness.

1. Hospice organizations educate patients, caregivers and families in safe and effective use of medical equipment and supplies.
2. The patient, family, and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII. 5 cont'd

D:	**Policies and procedures for laboratory services exist and include the 4 elements in HII.5k.**
D:	**Evidence exists that the outside laboratory/laboratories used by hospice are certified in the appropriate service. (HII.5k)**
D:	**Protocols exist for emergency and do-not-resuscitate situations. (HII.5l)**
I:	**Staff understands and provides examples of appropriate use of emergency and do-not-resuscitate protocols. (HII.5l)**
D:	**Complaint management system and documentation of complaints is evident. (HI.5m)**
D & I:	**Method for dealing with ethical issues is documented and described. (HI.5m)**

Hospice

HII.5k Laboratory services utilized are in compliance with licensing and regulatory standards.

1. **Hospice organizations performing diagnostic testing under CLIA waived status regulations possess a current certificate**
2. **Hospice organizations using outside laboratory services ensure that the laboratory is certified in the appropriate specialties and subspecialties of service**
3. **Validation of the outside laboratory compliance with CLIA is on file**
4. **Written policies and procedures address:**
   a) **Defined indications for testing**
   b) **Specimen collection, preservation, transport**
   c) **Reporting, follow up and referral activities**
   d) **Responsibilities and qualifications of personnel performing testing**
   e) **Patient education**
   f) **Documentation requirements**

HII.5l The Hospice organization complies with its protocols for medical emergencies.

HII.5m The Hospice organization complies with its system for dealing with complaints and ethical issues.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.6

D:	**Clinical records include the nine (9) elements and related sub-elements as delineated in HII.6a.**
D:	**Clinical records provide evidence of compliance with policies/procedures. (HII.6)**
D:	**Documentation supports appropriate clinical practice, including clinical supervision. (HII.6)**
D:	**Clinical records and/or minutes document fulfillment of IDT/IDG responsibilities. (HII.6)**

Hospice

HII.6 The Hospice establishes and maintains a clinical record for each individual receiving care and services. The record is complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

HII.6a The clinical record contains:

1. **Pertinent medical history**
2. **Consent and authorization forms**
3. **Patient/family/caregiver demographic and identifying information**
4. **Election of the Medicare Hospice Benefit, if applicable**
5. **Patient's advance directives, if executed, or documentation that such information has been received**
6. **Name/address/phone number of:**
   - **a) Contact person for emergencies and/or notification of death**
   - **b) Legal representative for fiscal and health care decisions, when applicable**
7. **Physician's name including primary, secondary and consulting, as appropriate**
8. **Medication profile including over-the-counter medications and:**
   - **a) Adverse reactions**
   - **b) Significant side effects**
   - **c) Drug allergies**
   - **d) Contraindications**
   - **e) Changes to medication therapy**
9. **Documentation:**
   - **a) Substantiating terminal diagnosis and criteria for admission**
   - **b) Patient's signed receipt of Bill of Rights**
   - **c) Patient/family/caregiver initial and updated comprehensive assessments**
   - **d) Plan of care developed/revised by IDT/IDG based on comprehensive assessments and desired outcomes with time frames**
   - **e) Documentation of responses to medications, symptom management, treatment and services**
   - **f) Change in interventions for ineffective drug therapies or other undesired outcomes**
   - **g) Regular pain assessments, interventions and outcomes, when applicable**
   - **h) Outcome measure data elements**
   - **i) IDT/IDG conferences and individual patient/family case conferences as indicated**
   - **j) Physician review of medications and plan of care oversight including justification for re-certification**
   - **k) Physician Certification and re-certification**
   - **l) Appropriate, current and signed medical orders by physician, in compliance with regulatory and accrediting bodies**
   - **m) Copies of summary reports sent to the physician, as appropriate**
   - **n) Summary of care provided in other settings, when indicated**
   - **o) Bereavement plan of care, including initial bereavement assessment and services being provided**
   - **p) Assessment for volunteer needs, referral, and documentation when indicated**
   - **q) Timely clinical notes documenting interventions, care and services provided**
     - **Acceptance by the patient/family of the diagnosis and prognosis**
     - **Attitudes and response of patient/family/caregiver to plan of care**
     - **Progress toward goals/outcomes of care**
   - **r) Verification of need for changing level of care, transfer to another hospice or revocation of services.**
   - **s) Discharge Summary, if applicable**
   - **t) Each entry is dated and signed, including title and credential, by the person providing the care/services**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.7

D: **Evidence exists that patients meet the eligibility criteria. (HII.7a)**

I: **Staff describes process for maintaining responsibility for professional management. (HII.7b)**

D: **Written agreements are available and include elements from CIII.2b, HIII.2b plus the 9 elements in HII.7c. (HII.7c)**

I: **Management describes mechanism to evaluate services provided through contractual arrangement and compliance with contract parameters. (HII.7c)**

Hospice

HII.7 Hospices that provide hospice care to residents of a SNF/NF or ICF/MR are in compliance with regulations stipulated in CFR 418.10 through 418.16 and CFR 418.112

HII.7a Medicare patients receiving hospice services and residing in a SNF/ NF, or ICF/MR are subject to the Medicare hospice eligibility criteria set out at § 418.20 through § 418.30. (418.112 (a))

HII.7b The hospice assumes responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice related inpatient care in a participating Medicare/Medicaid facility according to § 418.100 and § 418.108. (418.112 (b))

HII.7c The hospice has a legally binding written agreement with the SNF/NF or ICF/MR that specifies the provision of hospice services in the facility.
The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/MR before the provision of hospice services. The written agreement must include at least the following elements 1-9 and elements 1-7 of CIII.2b.

1. **The manner in which the SNF/NF or ICF/MR and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day.**
2. **A provision that the SNF/NF or ICF/MR immediately notifies the hospice if—**
   a) **A significant change in a patient's physical, mental, social, or emotional status occur;**
   b) **Clinical complications appear that suggest a need to alter the plan of care**
   c) **A need to transfer a patient from the SNF/NF or ICF/MR, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions**
   d) **A patient dies.**
3. **A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.**
4. **An agreement that it is the SNF/NF or ICF/MR responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.**
5. **An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/MR resident were in his or her own home.**
6. **A delineation of the hospice's responsibilities, which include, but are not limited to the following:**
   a) **Providing medical direction and management of the patient**
   b) **Nursing**
   c) **Counseling, including spiritual, dietary and bereavement**
   d) **Social work**
   e) **Provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions**
   f) **All other hospice services that are necessary for the care of the resident's terminal illness and related conditions.**
7. **A provision that the hospice may use the SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
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HII.7 cont'd

D: Written agreements are available and include elements from CIII.2b, HIII.2b plus the 9 elements in HII.7c. (HII.7c)

I: Management describes mechanism to evaluate services provided through contractual arrangement and compliance with contract parameters. (HII.7c)

D: A written plan of care exists for each patient and includes requirements specified in 1-4. (HII.7d)

D: Minutes of the IDT/IDG documents communication. (HII.7e.1, 2)

I: The IDG member assigned responsibility for overall coordination describes methods for achieving coordination and communication. (HII.7e1)

I: The SNF/NF or ICF/MR staff e describes coordination efforts. (HII.7e 1a-b)

D: Review of SNF/NF or ICF/MR records documents that the hospice provided the facility with the required information specified in HII.7e3a-g.

D: Documentation exists confirming orientation of staff which includes elements 1-5. (HII.7f)

Hospice

8. **A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.**
9. **A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff.**

HII.7d A written plan of care is established and maintained for every hospice patient by hospice in accordance with 42 CFR 418.56 and in consultation with SNF/NF or ICF/MR representatives.

1. **All hospice care provided is in accordance with the hospice plan of care.**
2. **The hospice plan of care identifies the care and services that are needed and specifically identified which provider is responsible for performing the respective functions agreed upon and included in the hospice plan of care.**
3. **The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible.**
4. **Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.**

HII.7e The hospice is responsible for ensuring coordination of services.

1. **The hospice designates a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/MR and assigns that member to be responsible for:**
   a) **Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives**
   b) **Communicating with SNF/NF or ICF/MR representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.**
2. **The hospice ensures that the hospice IDG communicates with the SNF/NF or ICF/MR medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.**
3. **The hospice provides the SNF/NF or ICF/MR with the following information:**
   a) **The most recent hospice plan of care specific to each patient**
   b) **Hospice election form and any advance directives specific to each patient**
   c) **Physician certification and recertification of the terminal illness specific to each patient**
   d) **Names and contact information for hospice personnel involved in hospice care of each patient**
   e) **Instructions on how to access the hospice's 24-hour on-call system**
   f) **Hospice medication information specific to each patient**
   g) **Hospice physician and attending physician (if any) orders specific to each patient**

HII.7f Hospice staff provide orientation to SNF/NF or ICF/MR staff furnishing care to hospice patients which includes:

1. **Hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control and symptom management**
2. **Principles about death and dying and individual responses to death**
3. **Patient rights**
4. **Appropriate forms**
5. **Record keeping requirements.**

LEGEND:

D - DOCUMENTATION
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HII.8

D: Compliance with regulations is documented including applicable inspection certificates, which are current and available for review, and verify no record of outstanding violation. (HII.8)

D, I, O: Mechanisms to assure 24-hour availability of nursing services and supervision are in place and described. (HII.8a)

I: Patients verbalize expected, appropriate care and services, conforming to plans of care, are provided, and observation supports patient's understanding. (HII.8a)

D: Staffing reports document presence of RN on each shift, as applicable. (HII.8b)

D, I, O: Mechanisms ensure a RN provides care on each shift, as applicable. (HII.8b)

O: The inpatient Hospice facility has a home-like décor. (HII.8c)

D & O: Policies and observation indicate compliance with safety procedures. (HII.8d, HII.8e)

D: Certificates indicate compliance with pertinent fire and safety codes, and with the Life Safety Code of the National Fire Protection Association (2000 Edition) or the CMS approved State Fire & Safety Code. (HII.8f)

I & O: Observation/interview with patient/family/caregiver confirms compliance with elements of HII.8c-f.

Hospice

HII.8 Inpatient services and facilities, operated/provided directly by the hospice, are in compliance with all applicable federal, state and local health and safety codes including the applicable provisions of the Life Safety

Code of the National Fire Protection Association (NFPA 101, Life Safety Code 2012 edition and Tentative Interim Amendments TIA 12-1, TIA 12–2, TIA 12–3, and TIA 12–4.) and the Health Care Facilities Code (NFPA 99 2012 edition and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, TIA 12–6, with the exception of chapters 7, 8, 12, and 13, which do not apply to hospice). Specific provisions of the Life Safety Code, which would result in unreasonable hardship on the hospice may be waived, for periods deemed appropriate, at the discretion of the State, CHAP, or the Secretary of Health and Human Services, if the waiver will not adversely affect the health and safety of patients. See §418.110(q) for provisions related to approval of incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 and information on inspecting a copy of the final rule. (HII.8 complies with revised 42 CFR 418.110 effective 7/5/2016)

HII.8a The inpatient hospice facility provides 24-hour nursing services that are:

1. **Sufficient to meet the patient's total nursing needs**
2. **In accordance with the patient plan of care for treatments, medication and diet as prescribed**
3. **Focused on insuring that the patient is kept comfortable, clean, well groomed and protected from accident, injury and infection**

HII.8b Each shift at the facility must include a registered nurse who provides direct patient care if at least one patient in the hospice facility is receiving general inpatient care.

HII.8c The inpatient hospice physical facilities have a home like decor and allow for the accomplishment of hospice objectives.

HII.8d The hospice maintains a safe physical environment, free from hazards for patients, staff and visitors.

HII.8e The hospice develops physical plant and equipment procedures to minimize threats to the health and safety of patients, staff and visitors, which include at a minimum:

1. **Routine storage and disposal of trash and medicated waste**
2. **Light, temperature and ventilation/air exchanges throughout the hospice**
3. **Emergency gas and water supply**
4. **Scheduled and emergency maintenance and repair of all equipment**

HII.8f The inpatient hospice rooms are designed and equipped for care, comfort and privacy of patients. Buildings have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement. The design of the room ensures that:

1. **Each patient room is located at or above ground level and contains no more than 2 beds**
2. **Space allotment for patient rooms provides for no less than 100 square feet per patient in a single room and no less than 80 square feet per patient in a double patient room.**

3. **Each patient room is equipped for nursing care and contains at a minimum:**
   - **a) A clean, comfortable and suitable bed**
   - **b) Closet space which provides security for personal belongings**
   - **c) A functional easily activated accessible device for calling staff members on duty**
   - **d) A place for personal effects such as pictures, clocks, etc.**
   - **e) Furniture suitable for comfort of patient/family/caregiver and visitors**
   - **f) Bathing and toiletry facilities within or in close proximity**
   - **g) A single station smoke detector if patient-owned upholstered furniture is used.**

LEGEND:

D - DOCUMENTATION
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HII.8 cont'd.

D: Policy reflects visitation to patient is available at any time and includes the five elements in HII.8g.

I: Patient/family/caregiver verbalizes satisfaction with privacy, comfort and visitation policy. (HII.8g)

O: Observation/interview with patient/family/caregiver confirms compliance with elements HII.8c-8g.

D: Policy/procedure defines system for storage of and access to drugs and biologicals, including emergency medications. (HII.8h3)

D, I, O: Facility can demonstrate criteria met. (HII.8h)

D & O: The facility maintains a sanitary environment and provides source documents for basis of controls. (HII.8i)

D: The infection control program is delineated in policy/procedure and/or infection control manual and is in compliance with CDC standards. (HII.8j)

D: Isolation procedures are delineated in policy/procedure and/or infection control manual. (HII.8k)

I: Staff describes infection control policies/procedures consistent with elements of HII.8j-k.

O: Practice is consistent with elements of HII.8j-k.

Hospice

HII.8g The physical space of the inpatient hospice facility allows families to have:

1. **Privacy during visits with patients**
2. **Accommodations to remain with patient throughout the night**
3. **Visiting at any hour**
4. **Visits from small children**
5. **Accommodations for privacy after the patient's death**
6. **Accommodation for a single room request for the patient whenever possible**

HII.8h The inpatient hospice facility ensures:

1. **An adequate supply of hot water at all times with provisions for automatic temperature regulation of the hot water used by patients**
2. **Linen is available in sufficient quantities to provide for the care and comfort of patients and is handled in a manner to prevent spread of contaminants**
3. **Storage facilities for drugs and biologicals include:**
   a) **Proper temperature controls**
   b) **Locked security**
   c) **Only authorized personnel have access**
   d) **Separately locked compartments for controlled drugs listed in Schedules II, III, IV, and V, with a system for accessing locked drugs in an emergency**
   e) **Rapid access to emergency medications**
4. **Nutrition therapy solutions are stored according to standards of practice.**
5. **Inpatient provider adheres to the hospice post-mortem procedures as defined by hospice policy and procedures**
6. **Emergency lighting is available with a 1 ½ hour capacity to remain on.**
7. **Cooridor doors and doors to rooms containing flammable or combustable materials are provided with positive latching hardware. Roller latches are prohibited on such doors.**

HII.8i The hospice must provide a sanitary environment by following current standards of practice, including nationally recognized infection control precautions and avoid sources and transmission of infections and communicable disease. If alcohol-based hand rub dispensers are used in the facility, the dispensers are installed in a manner that adequately protects against access by vunerable populations.

HII.8j The inpatient hospice facility has an infection control program based on current CDC recommendations in accordance with the CHAP Core Standards, includes elements in 418.60 (a) – (c) and includes additional provision for:

1. **Prevention of infectious organism transmission through identified inpatient procedures**
2. **Measures for assessing and identifying patients and staff at risk**
3. **Provisions for a safe environment which protects immunosuppressed patients and prevents spread of identified infections and/or communicable disease**
4. **Care of contaminated laundry, equipment and supplies**
5. **Procurement, storage, preparation, distribution of food under sanitary conditions**
6. **Monitoring and evaluating the effectiveness of precautions**

HII.8k The inpatient hospice isolation policies and procedures include:

1. **Definition of nosocomial infections and communicable diseases**
2. **Measures for prevention of outbreaks**
3. **Requirements for infected or immunosuppressed patients**
4. **Universal precautions, asepsis and sterilization techniques**
5. **Care and disposal of linens, dishes, supplies and equipment**
6. **Hand hygiene**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
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HII.8 cont'd.

D: Clinical record review reveals compliance with policies, regulations and physician orders. (HII.8l)

D: Personnel record review confirms that staff were trained in compliance with policies and regulations. (HII.8l)

D: Review of documents reveals that all deaths, if applicable, are reported to CMS in compliance with regulations. (HII.8m)

D: Clinical record review confirms that date and time of reported death to CMS is documented, if applicable. (HII.8m3)

D: Clinical notes document compliance, including recognition of symptoms related to nutrition and patient response to diet. (HII.8n)

I: Patient/family/caregiver describes interactions related to diet and nutrition and interventions designed to minimize symptoms and meet nutritional needs. (HII.8n)

O: Meal planning, storage, preparation and delivery comply with HII.8n3.

D: Licensed pharmacist oversees drug control system, which is defined in policies/procedures/manual and is compliance with elements in HII.8q.

D: Policies and procedures identify process to be used in the disposal of controlled drugs. (HII.8o)

D: Records document appropriate control and disposal of controlled drugs. (HII.8o)

I: Pharmacist describes drug control system, including accountability measures. (HII.8o)

O: Drug control system is in place. (HII.8o)

D: Review and analysis is recorded in meeting minutes and/or other reports. (HII.8p)

HII.8l The hospice uses restraint or seclusion with patients only to ensure the immediate physical safety of the patient, a staff member or others and complies with the regulations detailed in 418.110 (n) for the use of restraint and seclusion and in 418.110 (o) for the training of staff in the use of restraint and seclusion.

HII.8m The hospice reports deaths associated with the use of restraint or seclusion to CMS.

1. Reportable deaths include each unexpected death that occurs:
   a) While a patient is in restraint or seclusion
   b) Within 24 hours after the patient has been removed from restraint or seclusion
   c) Within 1 week after restraint or seclusion (if known and if reasonable to assume)

2. Deaths are reported to CMS no later than the close of business the next business day following knowledge of the patient's death.
3. The hospice documents in the patient's clinical record the date and time that the death was reported to CMS.

HII.8n The inpatient hospice furnishes meals to each patient that are:

1. Consistent with the patient's plan of care, nutritional needs and therapeutic diet
2. Palatable, attractive, and served at the proper temperature
3. Procured, stored, prepared, distributed and served under sanitary conditions

HII.8o The inpatient hospice provides accountability for all drugs and biologicals throughout the facility in accordance with State and Federal requirements, including:

1. Records of controlled drugs are maintained in sufficient detail to reflect accurate accounting of disposition and reconciliation
2. Discrepancies in the acquisition, storage, dispensing, administration, disposal or return of controlled drugs are investigated and reported to the appropriate State authority where required and a written account is available to State and Federal officials if required by law or regulation
3. Disposal of controlled substances no longer required by hospice inpatients are disposed of in compliance with hospice policies and State and Federal regulations

HII.8p The total number of inpatient days, used by Medicare beneficiaries who elected hospice coverage in any 12-month period preceding a certification survey, is reviewed to ensure the total does not exceed 20 percent of the total number of hospice days for this group of beneficiaries.

LEGEND:

D - DOCUMENTATION
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HII.8 cont'd.

D: Policies/procedures outline medication administration procedures and requirements as indicated in HII.8q.

D: Clinical and pharmacy records document adherence to pertinent policies/procedures, laws and regulations. (HII.8q)

D: Policies and procedures delineate requirements specific to the handling and dispensing of investigational drugs. (HII.8q4)

I: Staff verbalizes requirements of and adherence to policies, laws and regulations. (HII.8q)

I: Staff describes procedures for accessing necessary drugs, biologics equipment and supplies. (HII.8q)

D: The inpatient hospice internal/external disaster plan includes the elements of HII.8r, HII.8r1.

D: Participation in drills is recorded. (HII.8q2)

I: Staff describes disaster plans and drills, local resources and access procedures. (HII.8r2)

HII.8q The inpatient hospice ensures that drugs and biologicals are only administered by a licensed nurse, other health care professional in accordance with their scope of practice and State law, physician, an employee who has completed a State approved training program in medication administration, the patient's attending physician, or the patient/family as approved by the attending physician and designated by the hospice plan of care and in compliance with local, state and federal laws and regulations.

3. All medication administered to patients by the hospice staff must be ordered by a physician or a nurse practitioner in accordance with the plan of care and State law.
   a) If the order is verbal or electronically transmitted, the physician gives it only to a registered/licensed nurse, nurse practitioner (where appropriate), pharmacist or another physician
   b) The clinician receiving the verbal order signs it immediately and has the prescribing physician sign it in accordance with State and Federal regulations.

2. Each patient's medication container is labeled with the following information:

   a) Patient's full name
   b) Prescribing physician's name
   c) Name and strength of drug(s)
   d) Dose, method and frequency of administration
   e) Lot and control number
   f) Accessory and cautionary instructions
   g) Expiration date (if applicable)

3. Inpatient unit floor stock containers must contain, at a minimum, the following information:
   a) Name and strength of drug(s)
   b) Lot and control number
   c) Expiration date

4. Procedures are delineated for the handling of investigational drugs

HII.8r The inpatient hospice facility has a written internal and external disaster preparedness plan specific to its geographic location and facility residents for managing the consequences of power failures, natural disasters, and other emergencies affecting the hospice's ability to provide care.

1. The plan includes at a minimum the specific responsibilities assigned to personnel and procedures for:
   a) Official notification and communication procedures
   b) Identification and transfer of patients and records
   c) Emergency evacuation procedures for fire and internal disasters. When a sprinkler system is shut down for more than 10 hours in a 24 hour period the hospice must evacuate the bulding or portion of the building affected by the system outage until the system is back in service, or establish a fire watch until the system is back in service.
   d) Care of casualties (patients and staff) caused by the disaster
   e) Family notification procedures
   f) Arrangements with community resources
   g) Staff coverage procedures in the event of external disasters

2. The inpatient hospice facility conducts regular periodic rehearsed disaster drills with staff and non-employee staff consistent with code and also documents evaluation of procedures implemented.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.9

D:	**Clinical records indicate reason for inpatient hospitalization. (HII.9)**
I:	**Family/caregiver(s) verbalize knowledge of process for accessing inpatient care and consequences if hospice has not approved the change in patient's level of care. (HII.9)**
I:	**Clinicians describe appropriate use of short-term inpatient facility. (HII.9)**
D:	**Inpatient care for pain control or symptom management is provided in an appropriate facility, as specified in HII.9a.**
D:	**Inpatient respite care is provided in an appropriate facility, as specified in HII.9b.**
D:	**Criteria for short-term use of inpatient facility are available. (HII.9c)**

Hospice

HII.9 Short-term inpatient care is available for pain control, symptom management and/or respite purposes and must be provided in a participating Medicare or Medicaid facility.

HII.9a Inpatient care for pain control and symptom management is provided in one of the following settings:

1. **A hospice that meets the conditions of participation for providing inpatient care directly as specified in 42 CFR 418.110.**
2. **A hospital or SNF that also meets the standards specified in 42 CFR 418.110(b) & (e) regarding 24 hour nursing service and patient areas**

HII.9b Inpatient care for respite purposes is provided in one of the following settings:

1. **A hospice that meets the condition of participation for providing inpatient care as specified in 42 CFR 418.110.**
2. **A facility that meets the standards specified in 42 CFR 418.110(b) & (e) regarding 24 hour nursing services and patient areas**

HII.9c Criteria for the inpatient levels of care are clearly defined and may include but are not limited to:

1. **Pain evaluation to adjust medication and/or determine appropriate treatment**
2. **Intractable or protracted nausea incompatible with management in a home setting**
3. **Respiratory distress unmanageable in a home care setting**
4. **Open lesion(s) not responsive to home care and/or exacerbating symptom**
5. **Rapid decline related to varied factors such as bleeding, inconsistent with home care management**
6. **Death is imminent and family is unable to cope**
7. **Psychosis, severe confusion and/or combativeness secondary to end-stage disease process**
8. **Family/caregiver relief from demands of interventions required for end-of-life care**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.10

D: **Performance Improvement activities include evidence of monitoring for adequacy, appropriateness, effectiveness and outcome of care, services and supplies. (HII.10)**

D: **Performance Improvement activities include an integrated assessment of all levels of care including inpatient, home care and contracted care/service. (HII.10a)**

D: **Reports document that uniform data indicators are used to measure, monitor, and track and trend outcomes. (HII.10b3,4,5)**

D: **Record review documents involvement of all licensed personnel. (HII.10b7)**

D: **Tools used to collect and collate data that provide a basis for analysis are pertinent to the organization and include elements 1-10. (HII.10c)**

D: **Record review includes the appropriate sample number and components. (HII.10c5)**

D: **Reports document that data are tracked, trended and analyzed. (HII.10d)**

I: **Managers describe examples of how trended data were used to identify and correct problems. (HII.10d)**

D: **Projects are conducted and documented after February 2, 2009. (HII.10e)**

Hospice

HII.10 The adequacy, appropriateness, effectiveness and outcomes of care, services and supplies provided by hospice are routinely assessed.

HII.10a The Hospice organization conducts an ongoing comprehensive, data-driven, integrated self-assessment of care provided including inpatient care, home care, and care provided under arrangements to ensure the provision of high quality care, services and products.

HII.10b The performance improvement program:

1. **Reflects the complexity of its organization and services**
2. **Involves all hospice services, including those services furnished under contract or arrangement**
3. **Focuses on indicators related to improved palliative outcomes and is capable of showing measurable improvements in indicators**
4. **Utilizes quality indicator data to monitor effectiveness and safety and to identify opportunities and priorities for improvement**
5. **Measures, analyzes and tracks quality indicators, including adverse patient events**
6. **Takes action to demonstrate improvement in hospice performance**
7. **Involves all licensed professional employees**

HII.10c Patient focused quality assessment and improvement activities include:

1. **Comprehensive assessment and care planning**
   a) **Notification of significant changes to the agreed plan of care and scheduling of service**
   b) **Efforts are made to ensure the continuity of provision of care by designated staff**
2. **Patient teaching and levels of understanding**
3. **Determination of patient's discharge readiness**
4. **Use of findings from satisfaction surveys completed by the patient and/or family**
5. **Clinical record reviews are conducted on a routine basis from a random sample of 10% of unduplicated admissions with a maximum of 120 sample records per year. Record reviews include assessment of:**
   a) **compliance with plans of care**
   b) **appropriateness of care and services provided**
   c) **service duration**
   d) **high risk, high volume, or problem-prone areas – incidence, prevalence, severity**
   e) **adverse patient events**
6. **Safety issues**
7. **Evaluation of systems designed to support clinical operations**
8. **Compliance with standards of clinical practice**
9. **Reprioritization of performance activities**
10. **Integration of administrative, clinical and support functions**

HII.10d The findings are tracked, trended, analyzed and used by the hospice organization to correct identified problems and to revise hospice policies if necessary.

HII.10e Effective February 2, 2009, the hospice is required to implement performance improvement projects based upon patient and internal organizational needs and to document the projects conducted, the reasons for conducting the projects and the measurable progress achieved on the projects.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.11

D &O: **Documentation and observation validate compliance with policies and procedures for elements 1-5. (HII.1la)**

D: **Schedules and logs are available and current. (HII.1la)**

D: **A written safety program sets the parameters for monitoring environmental conditions and identifying potential hazards/risks in accordance with the 8 elements of HII.1lb.**

D: **Disaster/fire drills as appropriate are conducted and documented. (HII.1lc)**

I & O: **Staff describes and observation confirms the safety teaching provided to patients/families. (HII.11d)**

I & O: **Staff demonstrates knowledge of the practice and procedure. (HII.1le)**

Hospice

HII.11 The Hospice organization promotes the health and well being of employees and patients through education, current application of infection control practices and implementation of appropriate safety measures.

HII.11a Adherence to work practice and engineering controls is evident in practice.

1. **Written schedules for cleaning, disinfecting and decontaminating equipment and work surfaces**
2. **Process for selection of safer needle devices**
3. **Use of injury logs to document needle stick injuries from contaminated sharps**
4. **Clean technique vs. sterile (aseptic) technique**
5. **Handling, access and storage of medical gases**

HII.11b The organization has a written safety program to monitor environmental conditions for identifying potential hazards/risks including, but not limited to:

1. **Biomedical waste management**
2. **Storage and handling of environmental cleaning supplies**
3. **Fire safety**
4. **Preventive maintenance of equipment**
5. **Reporting of malfunctioning equipment**
6. **Environmental controls to prevent patient or staff accidents and or incidents**
7. **Safety of patients and employees in the community**
8. **Utilities**

HII.11c The organization conducts disaster/fire drills as applicable.

HII.11d Safety precaution teaching is provided to patients/families as appropriate, including handling, access and storage of medical gases. The patient, family and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.

HII.11e Staff demonstrates knowledge of the practices and procedures relating to referral of victims of abuse/neglect to the appropriate community agencies.

Hospice

HIII.

THE HOSPICE ORGANIZATION HAS ADEQUATE HUMAN, FINANCIAL AND PHYSICAL RESOURCES WHICH ARE EFFECTIVELY ORGANIZED TO ACCOMPLISH ITS STATED MISSION AND PURPOSE

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HIII.1

D: **Policies and procedures delineate mechanisms for maintaining an adequate workforce to provide hospice services. (HIII.1)**

I: **Mechanism for evaluating caseloads and workloads demands and variations are described. (HIII.1a)**

I & O: **Home visit frequency and type of service are appropriate. (HIII.1a)**

D & I: **Mechanisms for coping with peak patient loads are evident and consistent with federal regulations. (HIII.1a3)**

D: **Recruitment and hiring policies reflect designated elements. (HIII.1b)**

D: **Job Descriptions, orientation programs and competency based testing ensure adherence to professional standards of practice for all disciplines. (HIII.1b)**

I: **Mechanisms for employee and volunteer selection are described. (HIII.1b)**

D: **Personnel or administrative files contain evidence that criminal background checks are conducted in compliance with the standard and regulations. (HII.1b2 a-b)**

D: **Personnel or administrative files contain verification of education, either copies of transcripts/diplomas from schools accredited by their respective professional associations, or any other primary source verification. (HIII.1b3-4)**

D: **Evidence of verification of licenses, registration or certification for each employee, as appropriate, is available. (HIII.1b5)**

D: **Policies/procedures delineate mechanisms for assuring staff competency. (HIII.1b6)**

I: **Mechanisms for assessing and updating skills and competencies are described. (HIII.1b6)**

D: **Personnel files indicate paraprofessionals meet requirements. (HIII.1c)**

D: **Organization demonstrates compliance with state regulations and training programs. (HIII.1c-d)**

D: **Documentation of adequate training of the Hospice Aide is maintained. (HIII.1d1-2)**

I: **Paraprofessionals are able to describe their training course(s). (HIII.1d1-3)**

Note: *CMS has identified the requirements that a Hospice Aide training program and competency evaluation program or competency evaluation program must have for individuals to quality as home health aides in a Medicare participating hospice agency. (HIII.1d)*

Hospice

HIII.1 The hospice program has adequate and appropriate staff and services.

HIII.1a Staffing guidelines are developed and implemented to adequately meet caseload and workload demands on a 24-hour basis.

1. **Hospice employees substantially provide all core services**
2. **Volunteers are defined as employees**
3. **A mechanism exists to supplement staff during peak caseloads or unanticipated or extraordinary circumstances consistent with federal regulation CFR 42 418.64**

HIII.1b Staff are qualified for their respective responsibilities.

1. **All staff are selected based on:**
   a) **Qualifications, experience and training**
   b) **Communication and interpersonal skills**
   c) **Sensitivity to issues of loss and grief**
   d) **Ability to deal effectively with the demands of the job**
2. **The hospice obtains criminal background checks in accordance with State requirements on all hospice employees who have direct patient contact or access to patient records.**

   a) **Hospice contracts are to include the requirement for the contracted organization to obtain criminal background checks on all contracted employees.**
   b) **In the absence of State requirements, criminal background checks are to be obtained within three months of the date of employment for all states that the individual has lived or worked in the past three years.**
3. **Professional staff are graduates of schools approved or accredited by their respective professional associations/entities and meet qualifications specified in CFR 42 418.114 (b) (1) – (8)**
4. **Professional staff qualifications is evidenced via transcripts and/or diplomas**
5. **Staff who provide services have, and maintain, current licensure, certification or registration, as applicable, in accordance with applicable local/state/federal law and regulations and perform within the scope specified**
6. **The Hospice adheres to professional standards of practice and ensures staff performance is competency-based and routinely assessed**

HIII.1c Hospice Aide staff are qualified for their respective responsibilities.

1. **Hospice Aides receive adequate training by appropriate professional personnel**
2. **Hospice Aides demonstrate competency by maintaining a satisfactory rating in all required areas.**

HIII.1d A Hospice Aide training program meets all the standards for such programs as established by the Secretary of Health and Human Services.

1. **Hospice Aides receive a minimum of 75 hours of classroom and supervised practical training with at least 16 hours devoted to supervised practical training and with at least 16 hours of classroom instruction completed prior to beginning the supervised practical training.**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HIII.1 cont'd.

D: **Organization demonstrates compliance with state regulations and training programs. (HIII.1c-d)**

D: **Documentation of adequate training of the Hospice Aide is maintained. (HIII.1d1-2)**

I: **Paraprofessionals are able to describe their training course(s). (HIII.1d1-3)**

O: **Hospice Aides and homemakers perform competently. (HIII.1d2-3)**

D: **Documentation of adequate training and orientation for each Homemaker is available. (HIII.1d3)**

I: **Mechanisms for aide selection are described including application, results of interview and reference checks. (HIII.1d4)**

2. **The training curriculum provides trainees with an introduction to Hospice Aide services and instruction in:**
   a) **Overall responsibilities and limitations**
   b) **Communication techniques**
   c) **Patient's rights including ethics, confidentiality of care and respect for the patient and his/her property**
   d) **Observation, reporting and documentation of patient status and the care or service furnished**
   e) **Basic elements of body functions and changes in body functions that must be reported to an aide's supervisor**
   f) **Taking and recording temperature, pulse and respiration**
   g) **Infection control procedures**
   h) **Maintenance of a clean, safe and healthy environment**
   i) **Recognizing emergencies, knowledge of emergency procedures**
   j) **Care of patients served including the physical, emotional and developmental needs**
   k) **Bathing and personal care techniques including:**
   l) **Bed bath**
   m) **Sponge, tub or shower bath**
   n) **Sink, tub or bed shampoo**
   o) **Nail and skin care**
   p) **Oral hygiene**
   q) **Toileting and elimination**
   r) **Nutrition, meal preparation and fluid intake**
   s) **Normal range of motion**
   t) **Transfers, ambulation, positioning, and passive exercise**
   u) **Assistance with medications that are ordinarily self-administered as allowed per state regulations**

3. **Homemakers (environmental support or chore service personnel) successfully complete a minimum of 8 hours of training related to environmental support services including instruction in:**
   a) **Overall responsibilities and limitations**
   b) **Communication techniques**
   c) **Standards of supervision**
   d) **Ethics, confidentiality of patient care and patient rights**
   e) **Safety in the home and how to respond to emergencies**
   f) **Incidental household functions**
   g) **Procedures for maintaining a clean and healthful environment**
   h) **Infection control procedures related to food preparation and storage, laundry and handling waste**
   i) **Shopping**
   j) **Participating as a member of the interdisciplinary hospice care team**
   k) **Documentation of care and services provided in clinical records**

4. **Hospice Aide/Homemaker staff are selected based on the requirements of the job description and include:**
   a) **Experience**
   b) **Training**
   c) **Communication and interpersonal skills**
   d) **Ability to deal effectively with the demands of the job and population served**
   e) **Ability to work without consistent direct supervision**
   f) **Ability to read related written communication**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HIII.1 cont'd.

D: **Past training is documented in personnel files and meets requirements. (HIII.1d5)**

D: **A paraprofessional orientation program for employees not trained by the organization is documented. (HIII.1d5)**

D: **Qualifications of instructors and eligibility of organizations to provide competency program is Documented. (HII.1d6)**

D: **Competency testing is performed and documented for Hospice Aide prior to delivery of care and updated at least every 12 months thereafter. Personnel records reflect documentation of these activities. (HIII.1e 1-5)**

Note: CMS has identified the requirements that a Hospice Aide training program and competency evaluation program or competency evaluation program must have for individuals to quality as home health aides in a Medicare participating hospice agency. (HIII.1d)

D: **Policies and procedures delineate mechanisms for assessing competency and updating skills at least every 12 months. (HIII.1e 1-5)**

I: **Hospice Aide describes competency testing procedures. (HIII.1e2-3)**

D: **Completion of probationary/introductory period is documented for new paraprofessional employees. (HIII.1e4)**

D: **Supervisors meet required qualifications as documented by diplomas, licenses, resumes and reference checks. (HIII.1f1)**

D & I: **Policy and procedure delineate mechanisms assuring 24-hour availability of professional consultation and supervision of staff and volunteers. (HIII.1f2)**

D: **Clinical record documentation confirms home visits for supervision of, and coordination with, the LPN/LVN, LPTA, COTA occurring at least monthly or more often, as specified in state regulations. (HIII.1f5, 7)**

HIII.1d cont'd

5. The hospice assures that Hospice Aide/Homemaker personnel who have received their training outside the organization, whether employed or under contract, are appropriately prepared and qualified to provide hospice services.
   a) Demonstration of proficiency in required skill areas
   b) Provision of a comprehensive hospice orientation
6. The hospice is in compliance with 418.76 (e) and 418.76 (f) for qualifications of its hospice aide instructors and eligibility as an organization to provide a hospice aide competency evaluation program.

HIII.1e The Hospice Aides must complete a competency evaluation on all skills that are required in paragraph (b)(3) of section 418.76 (c) (1). (1) – (5).

1. Hospice Aide skills and competencies are assessed prior to delivery of services and updated at least every 12 months.
2. The competency evaluation, performed by a Registered Nurse in consultation with other skilled professionals as appropriate, is documented signed, dated and includes direct observation by the RN of all the required skills under paragraphs (b)(3) (i), (b)(3)(iii), (b)(3)(ix) and (b)(3)(xi)

   The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a Hospice Aide with a patient.
   a) Competency evaluation of TPR, personal care, transfer technique, ambulation assistance, range of motion and positioning are observed during observation of the Hospice Aide's performance of the tasks with a patient.
3. Competency is based on a "satisfactory" determination in all areas.
   a) If a Hospice Aide is not competent in one area, the Hospice Aide can be considered competent, but cannot perform the activity designated as "unsatisfactory" until performance in that area is evaluated as "satisfactory".
   b) A Hospice Aide is not competent if determined "unsatisfactory" in more than one area.
4. Successful completion of the probationary/introductory period per organization policy is documented, dated and signed by the employee and supervisor.
5. A Hospice Aide may not furnish hospice service until after successful completion of the competency program.

HIII.1f A qualified professional is responsible for the supervision of all direct care services.

1. Clinical supervisors possess professional education and experience commensurate with their assigned responsibilities
   a) Current licensure/registration and certifications as applicable
   b) A minimum of two (2) years of hospice experience (preferred)
2. Supervision and consultation is available to staff and volunteers during all hours of service
3. Licensed professional services provided directly or under arrangement are supervised by health care professionals who meet the appropriate qualifications specified under 418.114 and who practice under the hospice's policies and procedures.
4. When hospice professionals administratively report to a supervisor of a different discipline, provision is made for consultation and review with a professional manager in their own discipline in order to ensure adherence to and accountability for professional practice standards.
5. A home visit is made, at least monthly, by the appropriate professional (RN, PT, OT) to patients being seen by a licensed practical/vocational nurse (LPN/LVN), licensed physical therapy assistant (LPTA) or certified occupational therapy assistant (COTA). (More often if required by state law.)

LEGEND:

D - DOCUMENTATION
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HIII.1 cont'd.

D: **Clinical record documentation confirms home visits for supervision of, and coordination with, the LPN/LVN, LPTA, COTA occurring at least monthly or more often, as specified in state regulations. (HIII.1f5, 7)**

D: **Nursing and aide staff reports to a qualified RN. (HIII.1f6)**

I: **Supervisors are knowledgeable regarding care needs of patients. (HIII.1f6)**

D: **Policy/procedure dictates time frames for supervisory home visits (with or without the paraprofessional present) by the RN at least every 14 days for Hospice Aide or every month for homemaker. Supervisory encounters are documented in the patient's record. (HIII.1f6)**

D: **Follow-up onsite supervisory visits and competency evaluation is documented if concern areas Are documented by the supervisory nurse. (HIII.1f6d,e)**

D: **Care plans and job descriptions specify nursing responsibilities. (HIII.1f6,8)**

I: **Staff and volunteers assigned to a new job classification or assignment describe their orientation to the new responsibilities and patient needs. (HIII.1f8)**

D: **Records reflect required in-service hours. (HIII.1g)**

D: **Records reflect paraprofessional participation in continuing education and in-service education. (HIII.1g)**

D: **Competency evaluations are documented for all professionals and paraprofessionals at time of hire and every 12 months. (HIII.1h)**

D: **The competency evaluation process includes mechanisms for assessing skills, updating skills, and testing and observing skills performance every 12 months. (HIII.1h)**

D: **Records and documents reflect compliance with elements 1-3 in HIII.1i.**

6. Nursing and Hospice Aide services are under the supervision of a qualified registered nurse, who is available and accessible during all hours of operation.
   a) Hospice Aide and Homemaker supervisors possess at least two years of community based hospice, or home health experience
   b) A RN supervisory visit is made every 14 days to the patient's home when aide services are being provided to assess whether the aide is (i) following the
   c) patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse,(ii) creating successful interpersonal relationship with the patient and family, (iii) demonstrating competency with assigned tasks.
   d) The RN supervisory visit must assess quality of care and services provided by the hospice aide, and whether the IDT services ordered meet the patient's needs
   e) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.
   f) The aide may or may not be present during supervisory encounters which are scheduled as follows:
   g) Hospice Aide every 14 days
   h) Homemaker every month
   i) If an area of concern is noted by the supervising nurse during the onsite supervisory visit, the supervising nurse is to make a follow-up on-site supervisory visit with the aide present to observe the delivery of care.

   j) If the supervising nurse verifies the area of concern during the follow-up on-site visit with the hospice aide present, that hospice aide will complete a competency evaluation prior to providing further care.

1. Supervisory encounters are documented, dated and signed by the supervising professional.
2. Patient care responsibilities of nursing staff are specified in plans of care and job descriptions
3. Newly assigned staff or volunteers are oriented to specific responsibilities and patient needs when patient assignments change.

HIII.1g The organization provides or arranges for documented in-service and continuing education for paraprofessionals by competent instructors. Part of this education may be furnished while care is being provided to the patient. The annual minimum requirements are as follows:

1. Hospice Aides: 12 hours in each twelve (12) month period
2. Personal Care Workers: 8 hours
3. Homemaker/Chore Workers: 4 hours

HIII.1h Clinical competency evaluations are performed at time of hire and annually to assess employee basic skill levels for all staff/employees providing patient/family care.

HIII.1i The clinical competency procedures identify learning needs of employees and provide input into staff development/in-service planning.

1. Competency evaluation tools are tailored to each job category and the services provided

2. Clinical supervisors and/or peer reviewers assess performance of employees during joint visits in the clinical practice setting
3. Competency of supervisors and/or management staff is assessed by the individual's immediate superior and may include peer evaluation as a component of the process

LEGEND:

D - DOCUMENTATION
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HIII.1 cont'd.

D: Policies clearly identify the responsibilities of volunteers. (HIII.1j)

I: Volunteers describe and accept responsibility for their identified duties. (HIII.1j)

I & O: Measures to retain volunteers are in place. (HIII.1j1)

D: Volunteer services are provided and supervised in compliance with elements in HIII.1j2.

D: Documentation of volunteer supervision is available. (HIII.1j3)

I: Volunteer coordinator describes plans to increase services. (HIII.1j4)

D: Records of volunteer hours include information on the 5% criteria, and cost savings, and is reported on at least an annually. (HIII.1j4-5)

D: Volunteer recruitment brochures clearly identify any qualifications pertaining to volunteering after a death in the family. (HIII.1k)

D: Orientation for marketing and development staff includes information on the appropriate approaches to use with families when conducting marketing and development activities. (HIII.1k)

D: Care plans show evidence of addressing spiritual needs and other end of life issues. (HIII.1l)

D: IDT/IDG meeting minutes document regular participation of bereavement, spiritual counselor and/or clergy staff in the care planning process. (HIII.1l)

I: Patient/family/caregiver describes spiritual support provided. (HIII.1l)

D: Documentation of hospice training includes evidence of the elements listed in HIII.1m.

I: Employees describe training content. (HIII.1m)

Hospice

4. **The hospice documents the provision of in-service training provided on a rolling 12 month period.**

HIII.1j Volunteers are used in defined roles to support ancillary, administrative and/or patient care services and are treated as employees.

1. **Active and ongoing efforts to recruit and retain volunteers are documented**

2. **Volunteers are regularly supervised and services coordinated by a qualified and experienced professional hospice employee**
   a) **Written policies and procedures detail supervisory responsibility and activities**
   b) **Supervisory encounters are documented in the clinical record**
   c) **Volunteers receive an annual performance evaluation**
3. **Volunteer activities are documented to reflect services, time worked, continuing levels of activity and expansion of services achieved through use of volunteers**

4. **The hospice documents and maintains a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff.**
5. **The hospice must document cost savings achieved through the use of volunteers and include:**

   a) **Identification of necessary positions which are occupied by volunteers**
   b) **The work time spent by volunteers occupying those positions**
   c) **Estimates of the dollar costs which the hospice would have incurred if paid employees occupied the positions identified in (5) (a) for the amount of time specified in (5) (b)**

HIII.1k Written guidelines are established that encourage surviving family members to wait a minimum of one year following the patient's death to serve as direct care volunteers or in public relations activities.

1. **Written information is available to the community regarding the involvement of the patient, family and caregiver serving as a volunteer, in public relations or in other non-therapeutic activities within the hospice organization**
2. **Written guidelines are established for hospice staff members in working with patient and families and surviving family members as volunteers, in public relations or in other non-therapeutic activities**

HIII.1l Reasonable efforts are made by the Hospice Organization to provide clergy/representatives of religious organizations:

1. **Patients are advised of the availability of this spiritual support**
2. **Visits may be requested by patient/family/caregiver**

HIII.1m Ongoing training/continuing education is provided for all hospice direct care staff including volunteers and contract employees. This training includes, but is not limited to:

1. **Hospice philosophy, goals and services**
2. **Protection of patient/family rights, including confidentiality**
3. **Knowledge of advance directives and powers of attorney**
4. **Communication and documentation skills**
5. **IDT/IDG approach to care with RN as care coordinator**
6. **Physiological, psychosocial and spiritual aspects of terminal care**
7. **Protocols to deal with grievances and issues of ethical concern**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
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HIII.1 cont'd.

D: **Documentation of hospice training includes evidence of the elements listed in HIII.1m.**

I: **Employees describe training content. (HIII.1m)**

D: **Evidence exists documenting orientation of Hospice volunteers is tailored to specific jobs/tasks as delineated in elements of HIII.1n.**

I: **Volunteers describe an orientation consistent with HIII.1n.**

D: **Policy and operational procedures describe mechanisms for accessing support services for staff. (HIII.1o)**

I: **Staff describes emotional support measures available and their effectiveness. (HIII.1o)**

Hospice

8. Respect for cultural diversity and special communication needs
9. Bereavement care
10. Family dynamics and crisis management
11. Concepts of palliative versus curative care
12. Procedures for responding to medical emergencies and patient's death
13. Processes for communicating with the hospice staff and on-call protocols
14. Safety policies and procedures
15. Establishment of boundaries with patient/family/caregiver
16. Areas of potential conflict of interest
17. Staff request not to participate in aspects of care when faced with conflicting cultural, ethical or religious beliefs

HIII.1n Orientation of Hospice volunteers, whether direct care givers, support staff, ancillary and/or office staff, is tailored to the specific jobs/tasks to be performed and is consistent with accepted standards of hospice practice.

1. The orientation process addresses:
2. Duties to be performed
3. Associated responsibilities related to the tasks
4. Identification of the person(s) the volunteer reports to
5. Persons to contact for assistance and instruction
6. Hospice goals, service and philosophy
7. Confidentiality and the protection of patient's/family rights
8. Family dynamics, coping mechanisms and psychological issues surrounding terminal illness, death and bereavement
9. Procedures to be followed in the event of an emergency or following the death of a patient
10. Individual volunteer guidance

HIII.1o A system is available for providing emotional support to staff and volunteers.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HIII.2

D: **Policies and procedures document mechanisms for transitioning patients to a different level of care. (HIII.2)**

I: **Staff describes techniques for identifying a need for change in level of service. (HIII.2)**

D: **Written agreements are available and current for every service provided under arrangement. (HIII.2a)**

D: **Written agreements include elements 1-10. (HIII.2b)**

D: **Written inpatient agreements include HIII.2b plus the additional 9 elements in HIII.2c. (HIII.2c)**

I: **Management describes mechanism to evaluate services provided through contractual arrangement and compliance with contract parameters. (HIII.2b, HIII.2c)**

Hospice

HIII.2 The hospice program has established a mechanism for all levels of care provided, including written agreements/contracts where appropriate.

HIII.2a The Hospice has a legally binding written agreement for the provision of arranged services.

HIII.2b The agreement includes elements 1-7 of CIII.2b plus the following additional elements for hospice arranged services:

1. **The hospice assures the continuity of patient/family care in home, outpatient and inpatient settings.**
2. **Identification of services to be provided**
3. **A stipulation that services be provided with the express authorization of the hospice**
4. **The manner in which the contracted services are coordinated, supervised and evaluated by the hospice**
5. **The delineation of the role(s) of the hospice and the contractor in the admission process, patient family assessment/ and the interdisciplinary group care conferences**
6. **Requirements for documenting that services are provided in accordance with the agreement and the patient's plan of care**
7. **A stipulation that the services are provided in a safe and effective manner by qualified personnel**
8. **The hospice retains professional, administrative, fiscal and oversight responsibility for the staff and services provided under arrangement.**
9. **The hospice retains responsibility for payment for services.**
10. **The hospice retains exclusive authority to admit and discharge patients.**

HIII.2c When inpatient care is provided under arrangement, the written agreement includes elements required in CIII.2b and HIII.2b plus the following additional elements:

1. **The hospice ensures that inpatient care is furnished only in a facility that meets all applicable local, state, federal laws and regulations.**
2. **The inpatient provider is furnished a copy of the patient's plan of care that specifies the inpatient services to be furnished.**
3. **The inpatient provider has established policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients.**
4. **The hospice patient's inpatient medical record includes documentation of all inpatient services and events and a discharge summary.**
5. **A copy of the inpatient medical record and discharge summary is provided to the hospice on request.**
6. **The inpatient party responsible for the implementation of the provisions of the agreement.**
7. **The hospice retains responsibility for appropriate hospice care training of the personnel who provide inpatient care under the agreement, including responsibility for documentation of a description of the training and names of trainers.**
8. **A description of a method for verifying that elements 1-7 are met.**
9. **Inpatient provider agrees to abide by the hospice program's post-mortem procedures.**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HIII.2

D: **Written Medical Director agreement includes HIII.2b plus the additional elements/requirements in HIII.2d. (HIII.2c)**

D: **Evidence exists that the medical equipment service under contract meets the Medicare DMEPOS Quality and Accreditation Standards. (HIII.2e)**

D: **Written medical equipment services agreement includes HIII.2b plus the additional 11 elements in HIII.2f. (HIII.2f)**

I: **Management describes mechanism to evaluate services provided through contractual arrangement and compliance with contract parameters. (HIII.2d, HIII.2e, HIII.2f)**

HIII.2d When Medical Director service is provided under agreement, the written agreement includes the elements required in CIII.2b and HIII.2b plus the following additional requirements and elements:

1. **The hospice may contract with either of the following for Medical Director Services:**
   a) **A self-employed physician; or**
   b) **A physician employed by a professional entity or physicians group**
2. **The contract specifies the name of the physician who assumes the medical director responsibilities and obligations.**

HIII.2e When durable medical equipment and supplies are provided under contract, the hospice is to contract with a medical equipment supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR 424.57.

HIII.2f When hospice contracts with durable medical equipment suppliers for the provision of home medical equipment services to hospice patients, the agreement includes specific responsibilities as defined in CIII.2a-b, HIII.2b, and, in addition, includes provision for:

1. **Who is responsible for teaching the patient about the equipment**
2. **Hours when the HME company is available to the patient, including arrangements for servicing patients during "off hours"**
3. **Time frames for response to new HME referral and response to equipment failure for retrieval, replacement and repair, specifically:**
   a) **2 hours respond time maximum for life support**
   b) **24 hours response time maximum for non-life support**
4. **Assurance that equipment is cleaned according to the specific cleansing requirements between consumer's usage**
5. **Assurance that equipment is checked and maintained in accordance with manufacturer's instructions and by qualified individuals. In the absence of a manufacturer's recommendation for routine and preventative maintenance on a piece of equipment, the hospice must ensure that repair and routine maintenance policies are developed.**
6. **Maintenance of logs indicating equipment operational status, cleaning schedule and repair, when indicated**
7. **The responsibilities of the contractor and contractee including:**
   a) **Who assesses the need for HME**
   b) **Who contracts the HME supplier**
   c) **Who returns the HME when no longer needed**
8. **The procedure if the HME company does not have the specific equipment needed including:**
   a) **What time delay the consumer can expect**
   b) **How to obtain the equipment if the consumer cannot wait longer than 24 hours for the equipment**
9. **Who performs insurance checks to determine coverage and notifies consumer of coverage and prices**
10. **Who reports equipment failure to government bodies based on regulations that cause or contribute to patient death or serious injury**
11. **The mechanism used for assessing patient satisfaction of HME services**

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HIII.3

D: **Policy and procedure address the safety and security of data collection information in accordance with HIII.3a.**

I: **MIS manager or other designated party explains and demonstrates accessibility to and analysis of statistical information. (HIII.3b)**

I: **Staff describes how collected data is utilized at a functional level. (HIII.3b)**

Hospice

HIII.3 An effective and efficient management information system is utilized to ensure accountability at all levels of the hospice organization.

HIII.3a A system (manual or automated) for the collection and management of key administrative/managerial and clinical information utilizes established standards and defined data elements for the collection and processing of required information.

1. **Data collection is structured, routine, and timely**
2. **Access into the system is by authorized personnel**
3. **Security and confidentiality of the management information system is guaranteed**

HIII.3b The organization has access to internal and external databases that provide information relevant to care, service and product delivery.

1. **Statistical reports identify organizational trends and are used for planning purposes**
2. **Information obtained forms a basis for comparative analysis**
3. **Staff provides examples of how the data are utilized**

Hospice

HIV.

THE HOSPICE ORGANIZATION IS POSITIONED FOR LONG TERM VIABILITY

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HIV.1

D: **A hospice operational plan is completed. (HIV.1a)**

I: **Examples are provided demonstrating the use of Hospice data in management, planning and evaluation activities. (HIV.1a)**

D: **The inter-relationship between the hospice services plan and the overall organizational plan is evident. (HIV.1b)**

D: **Reports demonstrate that evaluation of the effectiveness of the service plan is ongoing and includes modifications as indicated and necessary. (HIV.1b)**

D: **Analysis of surveys demonstrates that the Hospice integrates consumer and community needs into its planning process. (HIV.1c)**

Hospice

HIV.1 The Hospice operational planning process reflects the organization's mission and is integrated into the overall organizational plan (as applicable).

HIV.1a The hospice operational plan is developed and/or revised on an ongoing basis.

HIV.1b The hospice plan is consistent with the organizational plan when the Hospice organization is part of a larger organization.

HIV.1c The hospice integrates consumer and community needs into its planning process.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
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S - SURVEY

HIV.2

D: An annual evaluation of the hospice organization's program and operations is conducted. (HIV.2)

I: Management describes the annual evaluation process and the way that the quality assessment findings are included. (HIV.2a)

D: The interrelationship between the hospice program evaluation and the overall organizational evaluation is evident when the hospice is part of a larger, multi-service organization. (HIV.2b)

Hospice

HIV.2 Annual evaluation of the Hospice organization provides the basis for future planning.

HIV.2a The findings from the quality assessment are included as part of the Hospice annual evaluation.

HIV.2b The hospice annual evaluation is consistent with and/or integrated into the overall organizational annual evaluation when the Hospice organization is part of a larger organization.

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HIV.3

O: **Innovative strategies have been developed and implemented to meet the consumer and community needs and capitalize on consumer and community opportunities. (HIV.3a)**

D: **Recognition of consumer and community needs and opportunities are evident as the basis for innovation. (HIV.3a-c)**

I: **Strategies for recognizing and developing cutting-edge hospice-specific innovations are described. (HIV.3b)**

Hospice

HIV.3 The Hospice management team fosters innovation within the hospice organization and brings strong leadership skills to industry related activities.

HIV.3a The Hospice Organization identifies and reaches market segments or populations in need of its services, using innovative approaches to meet community needs.

HIV.3b Management staff continually evaluates and updates services delivered based on new clinical knowledge, community needs and changes in the industry.

HIV.3c Community education and awareness of hospice services is promoted by all staff.

HV.

THE HOSPICE ESTABLISHES AND MAINTAINS AN EMERGENCY PREPAREDNESS PROGRAM THAT COMPLIES WITH ALL APPLICABLE FEDERAL, STATE, AND LOCAL EMERGENCY PREPAREDNESS REQUIREMENTS.*

Hospice

HV.1	**The organization has a documented emergency preparedness (EP) plan that address actions to be taken in the event of a natural or man-made disaster. The plan is compliant with local, state, and federal requirements. The organization implements its emergency preparedness (EP) plan during natural or man-made disasters.**

HV.1a The hospice develops and maintains an emergency preparedness (EP) plan, in compliance with applicable local, state, and federal emergency preparedness requirements. The plan:

1) **Is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach;**
2) **Includes strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the organization's ability to provide care;**
3) **Addresses patient population, including, but not limited to, the type of services the organization has the ability to provide in an emergency;**
4) **Addresses continuity of operations, including delegations of authority and succession plans;**
5) **Includes a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the organization's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts; and**
6) **Is reviewed and updated at least annually.**

HV.1b As part of its emergency preparedness (EP) plan, the hospice develops and maintains an EP communication plan that complies with local, state and federal requirements. The communication plan, including all contact information, is reviewed and updated at least annually. The plan includes:

1) **Names and contact information for personnel, entities providing services under arrangement, patients' physicians, and other hospices;**
2) **Contact information for the federal, state, tribal, regional, and local emergency preparedness staff and other sources of assistance;**
3) **Primary and alternate means for communicating with personnel and federal, state, tribal, regional, and local emergency management agencies;**
4) **A method for sharing information and medical documentation for patients under the organization's care, as necessary, with other health care providers to maintain the continuity of care;**
5) **A means, in the event of an evacuation, to release patient information as permitted by Health Insurance Portability and Accountability Act (HIPAA);**
6) **A means of providing information about the general condition and location of patients under the organizations care as permitted under HIPAA; and**
7) **A means of providing information about the hospice's inpatient occupancy needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.**

Hospice

HV.1c **Organizations that are part of a healthcare system consisting of multiple separately certified healthcare facilities that elect to have a unified and integrated emergency preparedness (EP) program may choose to participate in the healthcare system's coordinated EP program. If elected, the unified and integrated EP program:**

1) **Demonstrates that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program;**
2) **Is developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered;**
3) **Demonstrates that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program;**
4) **Meets the requirements of paragraphs §484.102 (a)(2), (3), and (4) or §418.113 (a)(2),(3), and (4);**
5) **Is based on a documented community-based risk assessment, utilizing an all-hazards approach;**
6) **Is based on a documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach; and**
7) **Includes integrated policies and procedures, a coordinated communication plan and training and testing programs.**

Hospice

HV.2 **The organization documents emergency preparedness (EP) policies and procedures based on their EP plan, when required by local, state, or federal law or regulation.**

HV.2a **The hospice develops and implements emergency preparedness (EP) policies and procedures, based on the emergency plan, risk assessment, and the communication plan. Policies and procedures are reviewed and updated at least annually. At a minimum, policies and procedures address:**

1) **Procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The organization informs local and state officials of any on-duty staff or patients that they are unable to contact;**
2) **Procedures to inform local and state officials about patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment;**
3) **A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records;**
4) **Use of the organization's personnel in an emergency and other emergency staffing strategies, including the process and role for integration of state and federally designated health care professionals to address surge needs during an emergency; and**
5) **Development of arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to patients.**

HV.2b **Policies and procedures for hospice operated inpatient facilities address:**

1) **A means to shelter in place for patients and hospice personnel who remain in the hospice;**
2) **Safe evacuation from the hospice which includes consideration of care and treatment needs of evacuees, personnel responsibilities, transportation, identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance;**
3) **The provision of subsistence needs for hospice personnel and patients, whether they evacuate or shelter in place, including food, water, medical, and pharmaceutical supplies; alternate sources of energy to maintain the temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems, and sewage and waste disposal;**
4) **A system to track the location of hospice personnel on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty personnel or sheltered patients are relocated during the emergency, the process includes documentation of the specific name and location of the receiving facility or other location; and**
5) **If the hospice is participating in a waiver under section 1135 of the Social Security Act, the inpatient hospice also addresses the role of the hospice in the provision of care and treatment at an alternate care site identified by emergency management officials.**

Hospice

HV.3	**Emergency preparedness training is provided to personnel. Training is specific to the individual's duties and responsibilities. Training is documented, including the dates, participants, and the content covered.**

HV.3a The hospice develops and maintains an emergency preparedness (EP) training program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan. The training program is reviewed and updated at least annually and includes:

1) The training program is reviewed and updated at least annually and includes:

a) Initial training (during orientation or shortly thereafter) in EP policies and procedures to all new and existing personnel, individuals providing services under arrangement, consistent with their expected roles; and

b) A periodic review and rehearsal of the organization's EP plan with hospice employees (including non-employee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

2) EP training is provided at least annually. The organization maintains documentation of the training, including the date(s), participants, and content covered. Personnel demonstrate knowledge of emergency procedures as part of the training.

Hospice

HV.4 **The organization tests its EP program at least annually and in accordance with its policy, or as required by local, state, or federal requirements.**

HV.4a **The organization develops and maintains an emergency preparedness (EP) testing program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan. The testing program is reviewed and updated annually.**

HV.4b **The organization conducts exercises to test the emergency preparedness (EP) plan annually, including:**

1) **Participation in a full-scale exercise that is community-based. When a community-based exercise is not accessible, testing includes participation in an individual, facility-based exercise. If the organization experiences an actual natural or man-made emergency that requires activation of the emergency plan, the organization is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; and**
2) **An additional exercise that includes a second full-scale exercise that is community-based or individual, facility based. Alternatively, the organization may conduct a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.**

Hospice

HV.5	**The organization analyzes its response to and maintains documentation of all drills, tabletop exercises, and emergency events, and revises the emergency plan as needed.**